BlueCross BlueShield of Texas

Prior Authorization/Step Therapy Program

This program encourages safe, cost-effective medication use by allowing coverage when certain conditions are met. A clinical team of physicians and pharmacists develops and approves the clinical programs and criteria by reviewing FDA-approved labeling, scientific literature and nationally recognized guidelines.

Prior Authorization

Drug Category	Target Drugs	Program Intent
Androgens/ Anabolic Steroids	Anadrol-50, Androderm, Androgel, Android, Androxy, Aveed, Axiron, danazol, Delatestryl, Depo-Testosterone, First-Testosterone, Fortesta, Methitest, Oxandrin, Striant, Testim, Testred, Vogelxo	Helps ensure that patients are appropriately selected and treated according to parameters defined in product labeling, clinical evidence and/or clinical guidelines. Upon meeting criteria, use of one of the preferred topical agents, Androderm or Androgel, is typically required before non-preferred topical products. A quantity limit is applied to all topical testosterone products. Both brand and generic agents are targeted.
Antifungal Agents	Noxafil, Vfend	Helps ensure appropriate selection of patients for treatment when prescribed for indications approved in product labeling. Both brand and generic agents are targeted.
Doxycycline/Minocycline	*Doxycycline products*: Acticlate, Adoxa, Alodox, Avidoxy DK, Doryx (and generic equivalents), doxycycline, Monodox, Morgidox Kit, Nicazeldoxy, Nutridox Kit, Ocudox Kit, Oracea, Oraxyl, Vibramycin *Minocycline products*: Dynacin, Minocin, Minocin Kit, Solodyn (and generic equivalents)	Helps ensure appropriate selection of patients for treatment according to product labeling, clinical studies and/or clinical guidelines and encourages use of first-line generic agents and topical acne products before use of targeted products, when appropriate.
Erectile Dysfunction	Caverject, Cialis, Edex, Levitra, Muse, Staxyn, Stendra, Viagra	Helps ensure appropriate selection of patients for therapy according to product labeling, clinical guidelines and/or clinical studies. If prescribed for benign prostatic hyperplasia (BPH), encourages the use of a generic alpha blocker prior to consideration of Cialis at the recommended FDA-approved dose. A quantity limit is applied to these agents.
Narcolepsy	Nuvigil, Provigil	Encourages appropriate use when prescribed according to product labeling or for MS-related fatigue in patients age 17 and older. Upon meeting criteria, use of generic modafinil is typically required before the brands Nuvigil or Provigil. A quantity limit encourages FDA-approved dosing. Both brand and generic agents are targeted.
Opioid Dependence	Bunavail, Suboxone, Subutex, Zubsolv	Helps ensure appropriate selection of patients for treatment according to product labeling, clinical guidelines and/or clinical studies. A quantity limit encourages FDA-approved dosing. Both brand and generic agents are targeted.
Transmucosal Immediate Release Fentanyl (formerly Oral/Nasal Fentanyl)	Abstral, Actiq, Fentora, Lazanda, Onsolis, Subsys	Encourages appropriate use for the treatment of breakthrough pain in cancer patients who are opioid-tolerant. A quantity limit is applied to these agents. Both brand and generic agents are targeted.

Specialty Prior Authorization

Drug Category	Target Drugs	Program Intent
Cushing's Disease	Signifor	Helps ensure appropriate use of Signifor in treatment of patients with Cushing's disease.
Enzyme Deficiency	Kuvan	Encourages use in patients with phenylketonuria (PKU) who are unable to maintain phenylalanine levels within the recommended range despite compliance with dietary restrictions. A quantity limit encourages FDA-approved dosing.
Erythropoiesis Stimulating Agents (ESAs)	Aranesp, Epogen, Procrit	Encourages appropriate use of ESAs to ensure that hemoglobin levels are within an acceptable range.
Familial Hypercholesterolemia	Juxtapid, Kynamro	Helps ensure appropriate use of Juxtapid and Kynamro in treatment of patients with homozygous familial hypercholesterolemia (HoFH). A quantity limit encourages FDA-approved dosing.
Growth Hormone/ Egrifta	Genotropin, Humatrope, Norditropin, Nutropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Tev-tropin, Zorbtive	Encourages appropriate use for patients diagnosed with growth hormone deficiencies. Upon meeting criteria, use of the preferred growth hormone Omnitrope is typically required before non-preferred products. Also helps ensure appropriate use of Egrifta in treatment of patients with HIV lipodystrophy. A quantity limit for Egrifta encourages FDA-approved dosing.
H.P. Acthar (Pituitary Hormone)	H.P. Acthar Gel	Helps ensure that patients are appropriately selected for therapy according to product labeling, clinical guidelines and/or clinical evidence. Verifies that appropriate FDA-approved dosing is used for specified indications. FDA-approved and/or clinically supported indications including, but not limited to, infantile spasms.
Hepatitis B & C	Harvoni, Infergen, Olysio, Pegasys, PegIntron, Sovaldi, Viekira	Helps ensure that patients are appropriately selected and treated for an appropriate duration of therapy according to parameters defined in product labeling, clinical evidence and/or clinical guidelines. Upon meeting criteria, use of the preferred brand pegylated interferon, Pegasys, is typically required before non-preferred products in treatment of Hepatitis C.
Huntington's Chorea	Xenazine	Encourages appropriate selection of patients for treatment of chorea associated with Huntington's disease. A quantity limit encourages FDA-approved dosing.
Idiopathic Thrombocytopenic Purpura (ITP)	Nplate, Promacta	Encourages appropriate, approved use for the treatment of chronic immune (idiopathic) thrombocytopenic purpura in those who have had an insufficient response to corticosteroids, immunoglobulins or splenectomy. A quantity limit encourages FDA-approved dosing.
Inherited Autoinflammatory Disorders	Arcalyst, Ilaris	Encourages use for FDA-approved indications and discourages use in place of anakinra for rheumatoid arthritis, and off-label uses. A quantity limit encourages FDA-approved dosing.
Kalydeco (Cystic Fibrosis)	Kalydeco	Encourages appropriate selection of cystic fibrosis patients for treatment according to product labeling, clinical studies, and/or clinical guidelines while following dosing recommended in product labeling. For use in the treatment of cystic fibrosis (CF) in those 6 years of age and older with ONE of the CFTR gene mutations as indicated in the FDA label. If the patient's genotype is unknown, an FDA-cleared mutation test should be performed.
Multiple Sclerosis	Ampyra	Encourages appropriate use in ambulatory patients with multiple sclerosis. A quantity limit encourages FDA-approved dosing.
Osteoporosis	Forteo	Encourages use of first-line medications, bisphosphonates or selective estrogen receptor modulators (SERMs), prior to the use of Forteo in the treatment of patients with osteoporosis or very low bone mineral density (BMD) (T score ≤ -3.5) according to FDA-approved labeling, clinical studies and/or treatment guidelines. A quantity limit encourages FDA-approved dosing.

Specialty Prior Authorization *(continued)*

Pulmonary Arterial Hypertension (PAH)	Adcirca, Adempas, Letairis, Opsumit, Orenitrum, Revatio, Tracleer	Helps ensure appropriate selection of patients for treatment according to product labeling, clinical studies and/or clinical guidelines. Upon meeting criteria, use of generic sildenafil is typically required before the brands Adcirca or Revatio unless the patient is already stabilized on the brand drug. A quantity limit encourages FDA-approved dosing. Both brand and generic agents are targeted.
Self-administered Oncology	Afinitor, Afinitor Disperz, Bosulif, Caprelsa, Cometriq, Erivedge, Gilotrif, Gleevec, Hexalen, Hycamtin, Iclusig, Imbruvica, Inlyta, Jakafi, Lynparza, Lysodren, Matulane, Mekinist, Nexavar, Oforta, Pomalyst, Revlimid, Sprycel, Stivarga, Sutent, Sylatron, Tafinlar, Tarceva, Targretin, Tasigna, Temodar, Thalomid, Tretinoin, Tykerb, Votrient, Xalkori, Xeloda, Xtandi, Zelboraf, Zolinza, Zykadia, Zydelig, Zytiga	Helps ensure appropriate selection of patients for treatment according to product labeling, clinical studies and/or clinical guidelines. A quantity limit encourages FDA-approved dosing.
Short Bowel Syndrome	Gattex	Helps ensure appropriate use of Gattex in the treatment of patients with short bowel syndrome (SBS).
Urea Cycle Disorders	Buphenyl, Ravicti	Helps ensure appropriate use of Buphenyl and Ravicti in patients with the following urea cycle disorders: carbamoylphosphate synthetase I deficiency (CPSID), ornithine transcarbamylase deficiency (OTCD), argininosuccinic acid synthetase deficiency (ASSD), argininosuccinic acid lyase deficiency (ASLD) or arginase deficiency (ARGD), who are not able to manage the disease by a protein restricted diet or with essential amino acid supplementation alone.
Xyrem	Xyrem	Encourages appropriate use in patients age 16 and older for the treatment of cataplexy and as a second-line agent to a stimulant for patients with a diagnosis of narcolepsy with excessive daytime sleepiness. A quantity limit encourages FDA-approved dosing.

Step Therapy

Drug Category	Target Drugs	Program Intent
Antidepressants	Aplenzin, Brintellix, Celexa, Cymbalta, desvenlafaxine ER tabs, Desvenlafaxine fumarate, Effexor, Effexor XR, Fetzima, fluoxetine 60 mg tabs, Forfivo XL, Khedezla, Lexapro, Luvox CR, maprotiline, Oleptro, Paxil, Paxil CR, Pexeva, Pristiq, Prozac, Prozac Weekly, Remeron, Remeron SolTab, venlafaxine ER tabs, Viibryd, Viibryd Starter Kit, Wellbutrin, Wellbutrin SR, Wellbutrin XL, Zoloft	Encourages use of cost-effective generic antidepressants for patients with new prescriptions for brand agents. The criteria also encourages use of first-line generic agents before Cymbalta when prescribed for neuropathic pain or fibromyalgia.
Cox-2/NSAID GI Protectant (Pain Management)	Celebrex, Duexis, Vimovo	Encourages use of more cost-effective NSAID alternatives in patients who are not at high risk for an adverse gastrointestinal event. A quantity limit encourages FDA-approved dosing.
Diabetes (GLP-1 Receptor Agonists)	Bydureon, Byetta, Tanzeum, Trulicity, Victoza	Encourages appropriate use for patients with a diagnosis of type 2 diabetes mellitus concomitantly treated with metformin; a sulfonylurea; a combination of metformin and a sulfonylurea; a combination of metformin or sulfonylurea and a thiazolidinedione or a basal insulin, such as Lantus or Levemir. A quantity limit encourages FDA-approved dosing.
Glucose Test Strips	All non-preferred brand test strips and disks	Encourages use of cost-effective preferred glucose test strip products before non-preferred products. A quantity limit is applied to all glucose test strips.
Lipid Management	Advicor, Altoprev, Lescol, Lescol XL, Lipitor, Liptruzet, Livalo, Mevacor, Pravachol, Simcor, Vytorin, Zocor	Encourages use of cost-effective generic HMG CoA reductase inhibitor (HMG) agents and preferred brand Crestor prior to the use of non-preferred brand HMG or HMG combination agents for the management of high blood cholesterol.

Specialty Step Therapy

Drug Category	Target Drugs	Program Intent
Biologic Immunomodulators (Rheumatoid Arthritis/Psoriasis)	Actemra subcutaneous, Cimzia, Enbrel, Entyvio, Humira, Humira starter kit, Kineret, Orencia subcutaneous, Otezla, Simponi, Stelara, Xeljanz	Upon meeting criteria, use of first-line medications is encouraged prior to the use of Humira and Enbrel. Also encourages use of preferred biologic immunomodulators, Humira and Enbrel, before use of a non-preferred biologic immunomodulator. A quantity limit encourages FDA-approved dosing.
Iron Chelator	Ferriprox	Helps ensure appropriate use for transfusional iron overload due to thalassemia syndromes after the use of Exjade, based on FDA-approved labeling, clinical studies and/or treatment guidelines.
Multiple Sclerosis	Aubagio, Avonex, Extavia, Gilenya	Encourages use of preferred agents prior to use of non-preferred agents. Coverage is allowed for only one disease-modifying agent at a time. A quantity limit encourages FDA-approved dosing.

These programs are included in the standard utilization management package and apply for most standard pharmacy benefit plans. Not all drug categories are included in all plans. Refer to the member's benefit materials or call the number on the back of the member's Blue Cross and Blue Shield of Texas ID card to determine whether a particular category is part of the member's benefit. The erectile dysfunction prior authorization program and infertility step therapy program do not apply to all pharmacy benefit plans.

This list is subject to change without notice. Call 800-289-1525 to confirm the status of a particular drug.