

Value Formulary Tiered Medicines with Clinical Requirements: Prior Authorization (PA)

Below is a list of medicines by drug class that require prior authorization based on certain clinical requirements for Value Formulary plans. If you continue using one of these medicines without authorization, you may be required to pay the full cost of the medicine.

If you are currently using one of these medicines, ask your doctor to provide authorization or to consider a plan medicine that does not require authorization.

Category* Drug Class	Medicines with Prior Authorization	Primary Clinical Requirements To Consider
<i>Allergenic Extracts</i>	GRASTEK (timothy grass pollen allergen extract)	Indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis.
	ODACTRA (house dust mite allergen extract)	Indicated as immunotherapy for house dust mite (HDM) induced allergic rhinitis.
	ORALAIR (sweet vernal, orchard, perennial rye, timothy, and Kentucky blue grass mixed pollens allergen extract)	Indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis.
	RAGWITEK (short ragweed pollen allergen extract)	Indicated as immunotherapy for the treatment of short ragweed pollen-induced allergic.
<i>Anticonvulsants</i>	NAYZILAM (QL)	Indicated for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 12 years of age and older.
	VALTOCO (<i>diazepam nasal spray</i>) (QL)	Indicated for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 6 years of age and older.
<i>Anti-Fungals – Imidazole Related</i>	NOXAFIL (posaconazole)	<p>Noxafil injection, delayed-release tablets, and oral suspension are indicated for prophylaxis of invasive <i>Aspergillus</i> and <i>Candida</i> infections in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy.</p> <p>Noxafil injection is indicated in patients 18 years of age and older.</p> <p>Noxafil delayed-release tablets and oral suspension are indicated in patients 13 years of age and older.</p>
<i>Anti-hyperlipidemics</i>	NEXLETOL (bempedoic acid)	Indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease who require additional lowering of LDL-C.
	NEXLIZET (bempedoic acid/ezetimibe)	Indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease who require additional lowering of LDL-C.
<i>Anti-Infectives, Antibacterials*</i>	DIFICID	Intended to be used only to treat severe or recurrent infections that are proven or strongly suspected to be caused by <i>Clostridium difficile</i> (CDI)
	<i>linezolid</i>	Intended to be used only to treat infections caused by susceptible strains of designated microorganisms in specific conditions
<i>Cardiovascular – Anti-Hyperlipidemics</i>	EPANOVA (omega-3-carboxylic acids) LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	<p><i>Epanova/LOVAZA is indicated as an adjunct to diet to reduce triglyceride levels in adult patients with severe hypertriglyceridemia.</i></p> <p><i>VASCEPA is indicated as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring</i></p>

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		hospitalization in adult patients with elevated triglyceride levels.
<i>Dermatologicals Topical NSAID</i>	SOLARAZE (diclofenac gel) 3% (QL)	Indicated for the topical treatment of actinic keratoses (AK).
<i>Fibromyalgia*</i>	SAVELLA	Intended for adult patients for the management of fibromyalgia
<i>Gastrointestinal Agents* Irritable Bowel Disease – Diarrhea Predominant</i>	VIBERZI	Intended for adult patients for the treatment of irritable bowel syndrome with diarrhea
	XIFAXAN 550	Intended to reduce the risk of overt hepatic encephalopathy (HE) recurrence in patients who are 18 years of age or older Also intended for adult patients for the treatment of irritable bowel syndrome with diarrhea
<i>Narcolepsy*</i>	<i>armodafinil</i>	Intended to improve wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea, narcolepsy and shift work disorder
	<i>modafinil</i>	
	XYREM [†]	Intended to treat cataplexy and excessive daytime sleepiness in narcolepsy (EDS)
<i>Opioid Dependence Agents*</i>	<i>buprenorphine sublingual</i> (QL)	Intended for the treatment of opioid dependence and is preferred for induction. These should be used as part of a complete treatment plan to include counseling and psychosocial support
<i>Opioid Analgesics</i>	Belbuca (600/750/9000 MCG Base Equivalent)	Belbuca is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
<i>Pain and Inflammation* Opioid Agents, Short-Acting</i>	ABSTRAL [†] (QL)	Intended for managing breakthrough pain in cancer patients who are already receiving around-the-clock opioid medicine for underlying cancer pain
	<i>fentanyl lozenges</i> (QL)	
	FENTORA [†] (QL)	
	LAZANDA [†] (QL)	
<i>Pain and Inflammation* Opioid Agents, Short-Acting</i>	ONSOLIS [†] (QL)	Intended for managing breakthrough pain in cancer patients who are already receiving around-the-clock opioid medicine for underlying cancer pain
	SUBSYS [†] (QL)	
<i>Pain Management</i>	Orlissa	Indicated for the management of moderate to severe pain associated with endometriosis.
<i>Pheochromocytoma Agents</i>	DIBENZYLIN (phenoxybenzamine) (QL)	Indicated in the treatment of pheochromocytoma, to control episodes of hypertension and sweating.
<i>Seizures</i>	ONFI [†] /clobazam	Indicated for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age or older
<i>Select Medical Devices Rx Only</i>	MUGARD; Various medications including wound dressings, eyelid cleansers, scar treatment products, oral wound care, dermatological products, occlusive silicone sheets, tetracaine gel, antiseborrheic products	Intended to ensure that select medical devices are utilized in accordance with indications or uses within the manufacturer's guidelines and to foster cost-effective, first-line use of available U.S. Food and Drug Administration (FDA)-approved medications and over-the-counter (OTC) products
<i>Select Artificial Saliva Medical Devices Rx Only</i>	Artificial saliva packets and solutions	Indicated for dryness of the mouth or throat (hyposalivation, xerostomia, mucositis)

The medicines indicated in this document with prior authorization, along with their clinical requirements, are subject to change.

There may be additional drugs subject to prior authorization or other plan design restrictions. Though covered by your plan, some generics may not be listed in your plan's formulary. Please consult your plan for further information.

This list represents brand products in CAPS, branded generics in upper- and lowercase, and generic products in lowercase *italics*. This is not an all-inclusive list of available drug alternative considerations. Log in to [Caremark.com](https://www.caremark.com) to check coverage and copay information for a specific drug. Copay means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan. Discuss this information with your doctor or health care provider. This information is not a substitute for medical advice or treatment. Talk to your doctor or health care provider about this information and any health-related questions you have. CVS Caremark® assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information. This list is subject to change.

Subject to applicable state law restrictions.

* This list indicates the common uses for which the drug is prescribed. Some drugs are prescribed for more than one condition.

† This indicates a non-listed brand and is subject to very high copay or exclusion (i.e., the plan does not cover the medicine) without an authorization for medical necessity.

Key abbreviations: (PA) = prior authorization; (QL) = quantity limit.

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