Disclaimer

Drug or product coverage is subject to formulary status. A medication or product listed on the policies herein may not be covered by your plan. Please refer to your plan's enhanced benefit portion of the formulary to determine what drugs are covered by your plan and are therefore subject to the following policies. Additionally, preferred product listings and the corresponding programs (i.e. the requirement to try and fail a preferred product) within the policies herein are not applicable for enhanced benefit coverage.

BlueCross BlueShield
Federal Employee Program

BREXAFEMME
(ibrexafungerp)

Patients who have filled at least a 1-day supply of fluconazole in the last 30 days are exempt from these Prior Authorization (PA) requirements.

Pre - PA Allowance

None

Prior-Approval Requirements

Patients who have filled at least a 1-day supply of fluconazole in the last 30 days are exempt from these Prior Authorization (PA) requirements.

Age 18 years of age or older **OR** post onset of menses

Diagnoses

Patient must have **ONE** of the following:

1. Vulvovaginal candidiasis (VVC)
2. Recurrent vulvovaginal candidiasis (RVVC)
    a. Used to reduce the incidence of RVVC

AND ALL of the following:

1. Inadequate treatment response, intolerance, or contraindication to fluconazole
2. **NOT** being used in a footbath
3. Females of reproductive potential **only**: patient will be advised to use effective contraception during treatment with Brexafemme and for 4 days after the last dose

Prior - Approval Limits

Indication	Quantity	Duration
Vulvovaginal candidiasis (VVC)	4 tablets	7 days
Recurrent vulvovaginal candidiasis (RVVC)	12 tablets per 90 days	6 months

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Prior – Approval *Renewal* Requirements

Each prior authorization (PA) request for Vulvovaginal candidiasis (VVC) is considered initiation of

BREXAFEMME
(ibrexafungerp)

therapy due to the acute nature of the infection

Age 18 years of age or older **OR** post onset of menses

Diagnosis

Patient must have the following:

1. Recurrent vulvovaginal candidiasis (RVVC)
    a. Used to reduce the incidence of RVVC

AND ALL of the following:

1. Prescriber has determined that the patient will benefit from an additional 6 months of therapy for prevention of RVVC
2. **NOT** being used in a footbath
3. Females of reproductive potential **only**: patient will be advised to use effective contraception during treatment with Brexafemme and for 4 days after the last dose

Prior - Approval *Renewal* Limits

Each prior authorization (PA) request for Vulvovaginal candidiasis (VVC) is considered initiation of therapy due to the acute nature of the infection

Indication	Quantity	Duration
Recurrent vulvovaginal candidiasis (RVVC)	12 tablets per 90 days	6 months (**ONE** renewal only)

BlueCross BlueShield
Federal Employee Program

CONTINUOUS GLUCOSE MONITORS (CGM) AND SUPPLIES

Dexcom G6, Dexcom G7, Freestyle Libre 14 day, Freestyle Libre 2, Freestyle Libre 3

Refer to the durable medical equipment benefit (DME) for coverage of all other CGM monitors and supplies.

Pre - PA Allowance

None

Prior-Approval Requirements

*Patients who have filled at least one cumulative ≥84 day supply of a single insulin, a glucagon-like peptide-1 (GLP-1) agonist injection indicated for the treatment of diabetes mellitus, or an insulin/GLP-1 combination injection **OR** have filled CGM/CGM supplies in the past 180 days are exempt from these Prior Authorization (PA) requirements up to the PA quantity limits.*

Diagnoses

Patient must have **ONE** of the following:

1. Type 1 Diabetes Mellitus

2. Type 2 Diabetes Mellitus **AND ALL** of the following:
   a. Insulin and/or GLP-1 agonist dependent with **ONE** of the following:
      i. > 3 insulin injections per day
      ii. Insulin pump therapy with frequent dosage adjustments for > 6 months
      iii. GLP-1 agonist injections, with or without insulin (See Appendix 1)
   b. Diabetes is uncontrolled AND patient has a documented average frequency of glucose self-testing at least 5 times per day during the previous two months
   c. HbA1c > 7.0% **OR** frequent hypoglycemic episodes
   d. Patient has completed a comprehensive diabetes education program
   e. Patient will share device readings with physician or healthcare professional as part of overall diabetes management
   f. **NO** dual therapy with blood glucose test strips at Prior Authorization (PA) quantities

Prior - Approval Limits

Quantity

BlueCross BlueShield
Federal Employee Program

CONTINUOUS GLUCOSE MONITORS (CGM) AND SUPPLIES

Dexcom G6, Dexcom G7, Freestyle Libre 14 day, Freestyle Libre 2, Freestyle Libre 3

Refer to the durable medical equipment benefit (DME) for coverage of all other CGM monitors and supplies.

System	Quantity Limit
Freestyle Libre 14 day	1 Monitor* per 365 days **AND** 6 sensors per 84 days
Freestyle Libre 2	
Freestyle Libre 3	
Dexcom G6	1 Monitor per 365 days **AND** 9 sensors per 90 days **AND** 1 transmitter* per 90 days
Dexcom G7	

**Not all systems require each component listed in this policy. Please refer to the documentation supplied with chosen system for its specific required components*

Duration 12 months

Prior – Approval *Renewal* Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Type 1 Diabetes Mellitus
2. Type 2 Diabetes Mellitus

AND the following for **ALL** diagnoses:

1. **NO** dual therapy with blood glucose test strips at Prior Authorization (PA) quantities

Prior - Approval *Renewal* Limits

Same as above

BlueCross BlueShield
Federal Employee Program

CONTINUOUS GLUCOSE MONITORS (CGM) AND SUPPLIES

Dexcom G6, Dexcom G7, Freestyle Libre 14 day, Freestyle Libre 2, Freestyle Libre 3

Refer to the durable medical equipment benefit (DME) for coverage of all other CGM monitors and supplies.

Appendix 1 -
Injectable GLP-1 Receptor Agonists Indicated for the Treatment of Diabetes Mellitus

Generic Name	Brand Name
Dulaglutide	Trulicity
Exenatide	Byetta
Exenatide ER	Bydureon, Bydureon BCise
Insulin Degludec and Liraglutide	Xultophy
Insulin Glargine and Lixisenatide	Soliqua
Liraglutide	Victoza
Lixisenatide	Adlyxin
Semaglutide	Ozempic
Tirzepatide	Mounjaro

BlueCross BlueShield
Federal Employee Program

CONDOMS
External (Male) Condoms, FC2 Female Condom

Pre - PA Allowance

Quantity 48 internal **OR** external condoms per 90 days

Prior-Approval Requirements

Diagnosis

Patient must have the following:

1. Patient has a clinical need for more than 48 condoms in 90 days, such as increased sexual activity, condom breakage, etc.

Prior - Approval Limits

Quantity 96 internal **OR** external condoms per 90 days
Duration 12 months

Prior – Approval *Renewal* Requirements

Same as above

Prior - Approval *Renewal* Limits

Same as above

BlueCross BlueShield
Federal Employee Program

DIABETES TEST STRIPS

Pre - PA Allowance

Quantity 6 test strips per day

Prior-Approval Requirements

Diagnosis

Patient must have the following:

Diabetes

AND ALL of the following must be provided

1) Directions for Use
2) Quantity required per 90 days
3) Reason for testing >6 times per day
4) NO dual therapy with Continuous Glucose Monitors (CGM) and/or Continuous Glucose Monitor supplies

Prior - Approval Limits

Quantity Up to 918 test strips every 90 days

Duration 6 months for gestational diabetes
1 year for other types of diabetes

Prior – Approval *Renewal* Requirements

Same as above

Prior – Approval *Renewal* Limits

Same as above

BlueCross BlueShield
Federal Employee Program

HYALURONIC ACID DERIVATIVES

Durolane, Euflexxa, **GelSyn-3**, GenVisc 850, **Hyalgan**, Sodium Hyaluronate, **Supartz**, Synojoynt, Triluron, TriVisc, Visco-3 (sodium hyaluronate)

Gel-ONE, Hymovis, Monovisc, Orthovisc (hyaluronan)

Synvisc, Synvisc-One (hylan G-F 20)

Bolded medications are the preferred products for claims adjudicated through the pharmacy benefit.

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years or older (22 or older for Synvisc, Synvisc-One, and TriVisc)

Diagnosis

Patient must have the following:

Osteoarthritis of the knee

AND ALL of the following:

1. Inadequate response to **TWO** or more of the following conservative non-pharmacologic therapy:
   a. Cardiovascular (aerobic) activity, such as: walking, biking, stationary bike, aquatic exercise
   b. Resistance exercise
   c. Weight reduction (for persons who are overweight)
   d. Participation in self-management programs
   e. Wear of medially directed patellar taping
   f. Wear of wedged insoles
   g. Thermal agents
   h. Walking aids
   i. Physical therapy
   j. Occupational therapy

2. Inadequate response, intolerance, or contraindication to **TWO** or more of the following:
   a. Acetaminophen
   b. Oral NSAIDs

HYALURONIC ACID DERIVATIVES

Durolane, Euflexxa, **GelSyn-3**, GenVisc 850, **Hyalgan**, Sodium Hyaluronate, **Supartz**, Synojoynt, Triluron, TriVisc, Visco-3 (sodium hyaluronate)

Gel-ONE, Hymovis, Monovisc, Orthovisc (hyaluronan)

Synvisc, Synvisc-One (hylan G-F 20)

Bolded medications are the preferred products for claims adjudicated through the pharmacy benefit.

c. Topical NSAIDs

3. Inadequate response, intolerance, or contraindication to intra-articular steroid injections in which efficacy lasted less than 8 weeks

4. Radiologic confirmation of Kellgren-Lawrence Scale score of grade 2 or greater

5. NO dual therapy with another hyaluronic acid injectable

6. **Non-preferred medications only:** Patient **MUST** have tried at least **TWO** of the preferred products if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g. inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Duration 12 months
Quantity One course of therapy for each knee

Prior – Approval *Renewal* Requirements

Age 18 years or older (22 or older for Synvisc, Synvisc-One, and TriVisc)

Diagnosis

Patient must have the following:

Osteoarthritis of the knee

AND ALL of the following:

1. Documentation of improvement in pain with previous course of treatment
2. At least 12 months has elapsed since last injection of the prior treatment cycle

HYALURONIC ACID DERIVATIVES

Durolane, Euflexxa, **GelSyn-3**, GenVisc 850, **Hyalgan**, Sodium Hyaluronate, **Supartz**, Synojoynt, Triluron, TriVisc, Visco-3 (sodium hyaluronate)

Gel-ONE, Hymovis, Monovisc, Orthovisc (hyaluronan)

Synvisc, Synvisc-One (hylan G-F 20)

Bolded medications are the preferred products for claims adjudicated through the pharmacy benefit.

3. Documentation of reduction of dosing of NSAIDs or other analgesics during the 12 month period following the last injection of the prior treatment cycle.
4. **NO** dual therapy with another hyaluronic acid injectable
5. **Non-preferred medications only:** Patient **MUST** have tried at least **TWO** of the preferred products if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g. inadequate treatment response, intolerance, contraindication)

Prior – Approval *Renewal* Limits

Same as above

BlueCross BlueShield
Federal Employee Program

OPIOID COUGH MEDICATIONS
Codeine with phenylephrine and promethazine
Codeine with promethazine
Hydrocodone polistirex, chlorpheniramine polistirex extended-release suspension
Hydromet/Hycodan (hydrocodone bitartrate, homatropine)
Tuxarin ER (codeine, chlorpheniramine)

Pre - PA Allowance

Age 12 years of age or older

Quantity

Drug Name	Quantity Limit*	Duration
Codeine with phenylephrine and promethazine	420 mL	30 days
Codeine with promethazine		
Hydromet/Hycodan (hydrocodone bitartrate, homatropine)		
Hydrocodone polistirex, chlorpheniramine polistirex extended-release suspension	140 mL	30 days
Hycodan (hydrocodone bitartrate, homatropine)	84 tablets	30 days
Tuxarin ER tablets (codeine, chlorpheniramine)	28 tablets	30 days

***** Quantity limits are the Package Insert maximum daily dose sufficient for 14 days of treatment. Cough requiring treatment longer than 14 days in a 30 day period will reject for prior authorization.

Prior-Approval Requirements

Prior authorization is not required if prescribed by an oncologist and/or the member has paid pharmacy claims for an oncology medication(s) in the past 6 months

Diagnoses

Patient must have **ONE** of the following:

1. Cough
    a. 18 years of age or older
    b. **NO** dual therapy with other opioid analgesic(s)
    c. Alternative treatment options have been ineffective, not tolerated or inadequate for controlling the patient's cough
        i. These include: Over-the-counter medications (dextromethorphan), and legend medications (benzonatate)

OPIOID COUGH MEDICATIONS
Codeine with phenylephrine and promethazine
Codeine with promethazine
Hydrocodone polistirex, chlorpheniramine polistirex extended-release suspension
Hydromet/Hycodan (hydrocodone bitartrate, homatropine)
Tuxarin ER (codeine, chlorpheniramine)

d. Prescriber agrees to assess patient for serotonin syndrome (see Appendix 1)
e. **NO** dual therapy with opioid addiction treatment or methadone
f. **NO** dual therapy with an anti-anxiety benzodiazepine(s)
    i. Alprazolam (Xanax)
    ii. Clonazepam (Klonopin)
    iii. Diazepam (Valium)
    iv. Lorazepam (Ativan)
    v. Oxazepam (Serax)
    vi. Chlordiazepoxide (Librium)
    vii. Clorazepate dipotassium (Tranxene)

2. Cough related to cancer or its treatment

Prior - Approval Limits

Quantity

Drug Name	Quantity Limit*	Duration
Codeine with phenylephrine and promethazine	900 mL	30 days
Codeine with promethazine	900 mL	30 days
Hydrocodone polistirex, chlorpheniramine polistirex extended-release suspension	300 mL	30 days
Hydromet/Hycodan (hydrocodone bitartrate, homatropine)	900 mL	30 days
Hycodan tablets (hydrocodone bitartrate, homatropine)	180 tablets	30 days
Tuxarin ER tablets (codeine, chlorpheniramine)	60 tablets	30 days

*Patients with cough related to cancer or its treatment are exempt from these quantity limits will receive a duration of 12 months

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Prior – Approval *Renewal* Requirements

Same as above

BlueCross BlueShield
Federal Employee Program

OPIOID COUGH MEDICATIONS
Codeine with phenylephrine and promethazine
Codeine with promethazine
Hydrocodone polistirex, chlorpheniramine polistirex extended-release suspension
Hydromet/Hycodan (hydrocodone bitartrate, homatropine)
Tuxarin ER (codeine, chlorpheniramine)

Prior - Approval *Renewal* Limits

Same as above

Appendix 1 - List of Serotonergic Medications

Selective Serotonin Reuptake Inhibitors (SSRIs)

paroxetine	Paxil, Paxil CR, Pexeva, Brisdelle
fluvoxamine	Luvox, Luvox CR
fluoxetine	Prozac, Prozac Weekly, Sarafem, Selfemra, Symbyax
sertraline	Zoloft
citalopram	Celexa
escitalopram	Lexapro

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

venlafaxine	Effexor XR
desvenlafaxine	Pristiq, Khedezla
duloxetine	Cymbalta
milnacipran	Savella

Tricyclic Antidepressants (TCAs)

amitriptyline	No brand name currently marketed
desipramine	Norpramin
clomipramine	Anafranil
imipramine	Tofranil, Tofranil PM
nortriptyline	Pamelor, Aventyl
protriptyline	Vivactil
doxepin	Zonalon, Silenor
trimipramine	Surmontil

Monoamine Oxidase Inhibitors (MAOIs)

isocarboxazid	Marplan
phenelzine	Nardil
selegiline	Emsam, Eldepryl, Zelapar

OPIOID COUGH MEDICATIONS

Codeine with phenylephrine and promethazine
Codeine with promethazine
Hydrocodone polistirex, chlorpheniramine polistirex extended-release suspension
Hydromet/Hycodan (hydrocodone bitartrate, homatropine)
Tuxarin ER (codeine, chlorpheniramine)

tranylcypromine	Parnate

Other Psychiatric Medicines

amoxapine	No brand name currently marketed
maprotiline	No brand name currently marketed
nefazodone	No brand name currently marketed
trazodone	Oleptro
buspirone	No brand name currently marketed
vilazodone	Viibryd
mirtazapine	Remeron, Remeron Soltab
lithium	Lithobid

Migraine Medicines

almotriptan	Axert
frovatriptan	Frova
naratriptan	Amerge
rizatriptan	Maxalt, Maxalt-MLT
sumatriptan	Imitrex, Imitrex Statdose, Alsuma, Sumavel Dosepro, Zecuity, Treximet
zolmitriptan	Zomig, Zomig-ZMT

Antiemetics

ondansetron	Zofran, Zofran ODT, Zuplenz
granisetron	Kytril, Sancuso
dolasetron	Anzemet
palonosetron	Aloxi

Other Serotonergic Medicines

dextromethorphan	Bromfed-DM, Delsym, Mucinex DM, Nuedexta
linezolid	Zyvox
cyclobenzaprine	Amrix
methylene blue	
St. John's wort	
tryptophan	

BlueCross BlueShield
Federal Employee Program

TEMODAR CAPSULES
(temozolomide)

Temodar injection is not included in this policy

Pre - PA Allowance

None

Prior-Approval Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Glioblastoma multiforme (GBM)
2. Astrocytoma

AND the following for **ALL** diagnoses:

a. Patient **MUST** have tried the preferred product (generic Temodar: temozolomide) unless the patient has a valid medical exception (e.g. inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Duration 12 months

Prior – Approval *Renewal* Requirements

Same as above

Prior - Approval *Renewal* Limits

Same as above

BlueCross BlueShield
Federal Employee Program

UPNEEQ
(oxymetazoline hydrochloride ophthalmic solution)

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have **ALL** of the following:

1. Acquired blepharoptosis (droopy eyelid)
   a. Condition impairs the visual field
   b. Prescribed by or recommended by an ophthalmologist
   c. Prescriber agrees to advise the patient of the signs and symptoms of acute angle closure glaucoma and to seek medical care if needed
   d. **NOT** exclusively for cosmetic use

Prior - Approval Limits

Quantity 90 single-use containers

Duration 3 months

Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have **ALL** of the following:

1. Acquired blepharoptosis (droopy eyelid)
   a. Patient has had an improvement in symptoms (e.g. improved field of vision)
   b. Prescribed by or recommended by an ophthalmologist
   c. Prescriber agrees to advise the patient of the signs and symptoms of acute angle closure glaucoma and to seek medical care if needed
   d. **NOT** exclusively for cosmetic use

BlueCross BlueShield
Federal Employee Program

UPNEEQ
(oxymetazoline hydrochloride ophthalmic solution)

Prior - Approval *Renewal* Limits

Quantity 90 single-use containers per 90 days

Duration 12 months

BlueCross BlueShield
Federal Employee Program

WEIGHT LOSS MEDICATIONS
Adipex-P* (phentermine), Lomaira (phentermine), phentermine
Benzphetamine
Contrave (naltrexone and bupropion)
Diethylpropion
Phendimetrazine
Plenity* (carboxymethylcellulose-cellulose-citric acid)
Qsymia (phentermine and topiramate extended-release)
Xenical (orlistat)

*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

Pre - PA Allowance

None

Prior-Approval Requirements

*Prior authorization for ****Adipex-P*** *and ****Plenity*** *applies only to formulary exceptions due to being a non-covered medication.*

Age **17 years of age or older**: *Adipex-P, Contrave, diethylpropion, Lomaira, phendimetrazine capsules, phentermine, Plenity
12 years of age or older: benzphetamine, phendimetrazine tablets, Qsymia, Xenical

Diagnosis

Patient must be using for the following:

Chronic weight management

AND ALL of the following:

1. Patient has **ONE** of the following:
    a. Age 18+, must have **ONE** of the following:
        i. Body mass index (BMI) ≥ 30 kg/m^2
        ii. Body mass index (BMI) ≥ 27 kg/m^2 **AND ONE** of the following:
            1. Patient has established cardiovascular disease (e.g., congenital heart disease, cerebrovascular disease, peripheral artery disease, coronary heart disease, acute coronary syndrome (ACS), myocardial infarction (MI), unstable angina, coronary or other arterial revascularization, or prior percutaneous coronary intervention/coronary bypass surgery)

BlueCross BlueShield
Federal Employee Program

WEIGHT LOSS MEDICATIONS
Adipex-P* (phentermine), Lomaira (phentermine), phentermine
Benzphetamine
Contrave (naltrexone and bupropion)
Diethylpropion
Phendimetrazine
Plenity* (carboxymethylcellulose-cellulose-citric acid)
Qsymia (phentermine and topiramate extended-release)
Xenical (orlistat)

*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

2. Patient has at least one weight related comorbid condition (e.g., type 2 diabetes mellitus, dyslipidemia, or hypertension)

b. Age 12-17 **ONLY**: Body mass index (BMI) ≥95th percentile for their age

2. Patient has participated in a comprehensive weight management program (e.g., Teladoc or another weight loss program)
3. **NO** dual therapy with another Prior Authorization (PA) medication for weight loss (see Appendix 1)

Prior - Approval Limits

Quantity

Medication	Quantity Limit
Benzphetamine	270 tablets per 90 days **OR**
Contrave	360 tablets per 90 days **OR**
Diethylpropion 25mg	270 tablets per 90 days **OR**
Diethylpropion 75mg	90 tablets per 90 days **OR**
Lomaira	270 tablets per 90 days **OR**
Phendimetrazine 35mg	270 tablets per 90 days **OR**
Phendimetrazine 105mg	90 capsules per 90 days **OR**
Phentermine	90 units per 90 days **OR**
Qsymia	90 capsules per 90 days **OR**
Xenical	270 capsules per 90 days **OR**

Medication **with approved formulary exception only**	Quantity Limit
Adipex-P	90 units per 90 days **OR**
Plenity	504 capsules per 84 days

BlueCross BlueShield
Federal Employee Program

WEIGHT LOSS MEDICATIONS
Adipex-P* (phentermine), Lomaira (phentermine), phentermine
Benzphetamine
Contrave (naltrexone and bupropion)
Diethylpropion
Phendimetrazine
Plenity* (carboxymethylcellulose-cellulose-citric acid)
Qsymia (phentermine and topiramate extended-release)
Xenical (orlistat)

*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

Duration 6 months

Prior – Approval *Renewal* Requirements

*Prior authorization for ***Adipex-P** and ***Plenity** applies only to formulary exceptions due to being a non-covered medication.*

Age **17 years of age or older**: *Adipex-P, Contrave, diethylpropion, Lomaira, phendimetrazine capsules, phentermine, Plenity
12 years of age or older: benzphetamine, phendimetrazine tablets, Qsymia, Xenical

Diagnosis

Patient must be using for the following:

Chronic weight management

AND ALL of the following:

1. Age 18+ **ONLY**: The patient has lost at least 5 percent of baseline body weight **OR** the patient continued to maintain their initial 5 percent weight loss
2. Age 12-17 **ONLY**: Patient has maintained clinically significant weight loss
3. Patient has participated in a comprehensive weight management program (e.g., Teladoc or another weight loss program)
4. **NO** dual therapy with another Prior Authorization (PA) medication for weight loss (see Appendix 1)

Prior - Approval *Renewal* Limits

Quantity

Medication	Quantity Limit
Benzphetamine	270 tablets per 90 days **OR**

BlueCross BlueShield
Federal Employee Program

WEIGHT LOSS MEDICATIONS

Adipex-P* (phentermine), Lomaira (phentermine), phentermine
Benzphetamine
Contrave (naltrexone and bupropion)
Diethylpropion
Phendimetrazine
Plenity* (carboxymethylcellulose-cellulose-citric acid)
Qsymia (phentermine and topiramate extended-release)
Xenical (orlistat)

*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

Contrave	360 tablets per 90 days **OR**
Diethylpropion 25mg	270 tablets per 90 days **OR**
Diethylpropion 75mg	90 tablets per 90 days **OR**
Lomaira	270 tablets per 90 days **OR**
Phendimetrazine 35mg	270 tablets per 90 days **OR**
Phendimetrazine 105mg	90 capsules per 90 days **OR**
Phentermine	90 units per 90 days **OR**
Qsymia	90 capsules per 90 days **OR**
Xenical	270 capsules per 90 days **OR**

Medication with approved formulary exception only	**Quantity Limit**
Adipex-P	90 units per 90 days **OR**
Plenity	504 capsules per 84 days

Duration 12 months

BlueCross BlueShield
Federal Employee Program

WEIGHT LOSS MEDICATIONS

Adipex-P* (phentermine), Lomaira (phentermine), phentermine
Benzphetamine
Contrave (naltrexone and bupropion)
Diethylpropion
Phendimetrazine
Plenity* (carboxymethylcellulose-cellulose-citric acid)
Qsymia (phentermine and topiramate extended-release)
Xenical (orlistat)

*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

Appendix 1 - List of PA Weight Loss Medications

Generic Name	Brand Name
benzphetamine	N/A
carboxymethylcellulose-cellulose-citric acid	Plenity
diethylpropion	N/A
liraglutide	Saxenda
naltrexone/bupropion	Contrave
orlistat	Xenical
phendimetrazine	N/A
phentermine	Adipxex-P/Lomaira
phentermine/topiramate ER	Qsymia
semaglutide	Wegovy
setmelanotide	Imcivree
tirzepatide	Zepbound

BlueCross BlueShield
Federal Employee Program

SAXENDA (liraglutide)
WEGOVY (semaglutide)

Pre - PA Allowance

None

Prior-Approval Requirements

Age 12 years of age or older

Diagnosis

Patient must be using for the following:

Chronic weight management

AND ALL of the following:

1. Patient has **ONE** of the following:
    a. Age 18+, must have **ONE** of the following:
        i. Body mass index (BMI) ≥ 30 kg/m^2
        ii. Body mass index (BMI) ≥ 27 kg/m^2 **AND ONE** of the following:
            1. Patient has established cardiovascular disease (e.g., congenital heart disease, cerebrovascular disease, peripheral artery disease, coronary heart disease, acute coronary syndrome (ACS), myocardial infarction (MI), unstable angina, coronary or other arterial revascularization, or prior percutaneous coronary intervention/coronary bypass surgery)
            2. Patient has at least one weight related comorbid condition (e.g., type 2 diabetes mellitus, dyslipidemia, or hypertension)
    b. Age 12-17 **ONLY**: Body mass index (BMI) ≥95th percentile for their age
2. Patient has participated in a comprehensive weight management program (e.g., Teladoc or another weight loss program)
3. **NO** dual therapy with other glucagon-like peptide-1 (GLP-1) receptor agonists (see Appendix 1)
4. **NO** dual therapy with another Prior Authorization (PA) medication for weight loss (see Appendix 2)

BlueCross BlueShield
Federal Employee Program

SAXENDA (liraglutide)
WEGOVY (semaglutide)

Prior - Approval Limits

Quantity

Medication	Quantity Limit
Saxenda	15 pre-filled pens per 90 days **OR**
Wegovy	12 single-dose pens per 84 days

Duration 6 months

Prior – Approval *Renewal* Requirements

Age 12 years of age or older

Diagnosis

Patient must be using for the following:

Chronic weight management

AND ALL of the following:

1. Age 18+ **ONLY**: The patient has lost at least 5 percent of baseline body weight **OR** the patient has continued to maintain their initial 5 percent weight loss
2. Age 12-17 **ONLY**: Patient has maintained clinically significant weight loss
3. Patient has participated in a comprehensive weight management program (e.g., Teladoc or another weight loss program)
4. **NO** dual therapy with other glucagon-like peptide-1 (GLP-1) receptor agonists (See Appendix 1)
5. **NO** dual therapy with another Prior Authorization (PA) medication for weight loss (see Appendix 2)

Prior - Approval *Renewal* Limits

Quantity

Medication	Quantity Limit
Saxenda	15 pre-filled pens per 90 days **OR**
Wegovy	12 single-dose pens per 84 days

Duration 12 months

BlueCross BlueShield
Federal Employee Program

SAXENDA (liraglutide)
WEGOVY (semaglutide)

Appendix 1 - List of GLP-1 Agonist Medications

Generic Name	Brand Name
dulaglutide	Trulicity
exenatide	Byetta
exenatide	Bydureon, Bydureon BCise
liraglutide	Saxenda
liraglutide	Victoza
liraglutide and insulin degludec	Xultophy
lixisenatide	Adlyxin
lixisenatide and insulin glargine	Soliqua
semaglutide	Ozempic
semaglutide	Rybelsus
semaglutide	Wegovy
tirzepatide	Mounjaro
tirzepatide	Zepbound

Appendix 2 - List of PA Weight Loss Medications

Generic Name	Brand Name
benzphetamine	N/A
carboxymethylcellulose-cellulose-citric acid	Plenity
diethylpropion	N/A
liraglutide	Saxenda
naltrexone/bupropion	Contrave
orlistat	Xenical
phendimetrazine	N/A
phentermine	Adipxex-P/Lomaira
phentermine/topiramate ER	Qsymia
semaglutide	Wegovy
setmelanotide	Imcivree
tirzepatide	Zepbound

BlueCross BlueShield
Federal Employee Program

XELODA
(capecitabine)

Pre - PA Allowance
None

Prior-Approval Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Colon cancer
2. Rectal cancer
3. Colorectal cancer
4. Breast cancer
5. Gastric, esophageal, or gastroesophageal junction cancer
6. Pancreatic cancer

AND the following for **ALL** diagnoses:

a. Patient **MUST** have tried the preferred product (generic Xeloda: capecitabine) unless the patient has a valid medical exception (e.g. inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits
Duration 12 months

Prior – Approval *Renewal* Requirements
Same as above

Prior - Approval *Renewal* Limits
Same as above