STEP THERAPY PROGRAMS

How do I request an exception to the Ultimate Health Plans' SNP Formulary?

You can ask Ultimate Health Plans to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Ultimate Health Plans limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Ultimate Health Plans will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

Your prescriber must submit a statement supporting your coverage determination or exception request. In order to help us make a decision more quickly, you should include supporting medical information from your prescriber when you submit your exception request.

What if I have additional questions?
You can call us at: 1-800-311-7517 (seven days a week, 24 hours a day) if you have any additional questions. If you have a hearing or speech impairment, please call us at TTY 1-866-706-4757.

dpp4 inhibitors

Products Affected

- JANUMET TABLET 50-1000 MG ORAL
- JANUMET TABLET 50-500 MG ORAL
- JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ORAL
- JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL
- JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL
- JANUVIA TABLET 100 MG ORAL
- JANUVIA TABLET 25 MG ORAL
- JANUVIA TABLET 50 MG ORAL
- JENTADUETO TABLET 2.5-1000 MG ORAL
- JENTADUETO TABLET 2.5-500 MG ORAL
- JENTADUETO TABLET 2.5-850 MG ORAL
- JENTADUETO XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL
- JENTADUETO XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL
- TRADJENTA TABLET 5 MG ORAL

Details	
Criteria	Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, or pioglitazone/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

glp1 agonist

Products Affected

- TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML SUBCUTANEOUS
- VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS

Details

Criteria	Trulicity and Victoza shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, or pioglitazone/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. Members with type 2 diabetes and multiple cardiovascular risk factors or established cardiovascular disease are exempt from the step requirements. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

leukotriene modifiers

Products Affected

- ZYFLO TABLET 600 MG ORAL

Details	
Criteria	Zyflo shall be considered medically necessary for members who have had an adequate trial of one month of therapy on montelukast or zafirlukast within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

Namzaric

Products Affected

- NAMZARIC CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG ORAL
- NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG ORAL
- NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 21-10 MG ORAL
- NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 28-10 MG ORAL
- NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 7-10 MG ORAL

Details	
Criteria	Namzaric shall be considered medically necessary for members who have had an adequate trial of one month of therapy on generic memantine extended release within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

pd agents

Products Affected

- NEUPRO PATCH 24 HOUR 1 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 2 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 3 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 4 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 6 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 8 MG/24HR TRANSDERMAL

Details	
Criteria	Neupro shall be considered medically necessary for members who have had an adequate trial of one month of therapy on the following therapy: pramipexole, pramipexole er, ropinirole, or ropinirole er within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

rytary

Products Affected

- RYTARY CAPSULE EXTENDED RELEASE 23.75-95 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 36.25-145 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 48.75-195 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 61.25-245 MG ORAL

Details	
Criteria	Rytary shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: amantadine, carbidopa/entacapone/levodopa, carbidopa/levodopa, carbidopa/levodopa er, carbidopa, entacapone, pramipexole, pramipexole er, ropinirole, ropinirole er, selegiline, or tolcapone within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

sglt2

Products Affected

- INVOKAMET TABLET 150-1000 MG ORAL
- INVOKAMET TABLET 150-500 MG ORAL
- INVOKAMET TABLET 50-1000 MG ORAL
- INVOKAMET TABLET 50-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL
- INVOKANA TABLET 100 MG ORAL
- INVOKANA TABLET 300 MG ORAL
- JARDIANCE TABLET 10 MG ORAL
- JARDIANCE TABLET 25 MG ORAL
- SYNJARDY TABLET 12.5-1000 MG ORAL
- SYNJARDY TABLET 12.5-500 MG ORAL
- SYNJARDY TABLET 5-1000 MG ORAL
- SYNJARDY TABLET 5-500 MG ORAL

Details

Criteria	Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, or pioglitazone/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. Members with type 2 diabetes and diabetic nephropathy, multiple cardiovascular risk factors, or established cardiovascular disease are exempt from the step requirements. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

statins

Products Affected

- LIVALO TABLET 1 MG ORAL
- LIVALO TABLET 2 MG ORAL
- LIVALO TABLET 4 MG ORAL

Details

Criteria	Livalo shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: atorvastatin, fluvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, or simvastatin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

UBRELVY

Products Affected

- UBRELVY TABLET 100 MG ORAL
- UBRELVY TABLET 50 MG ORAL

Details	
Criteria	Ubrelvy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: almotriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan, or zolmitriptan within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

Index of Drugs