

**FORMULARY EXCLUSIONS**

**SPECIFIC EXCLUSIONS**

**Certain HIV Medications**

Specific Eli Lilly drugs (generics are allowed)  
Antirheumatic injectables  
Botulinum toxin  
Compounded medications for infusion  
(Active medication containing more than one ingredient)  
Gonadotropin  
Finasteride (Propecia)  
(Approved for prostate disorders only)  
Hyaluronic acid derivatives  
Immune globulin intravenous (IGIV)

Injectable muscle relaxants  
Mifepristone  
Minoxidil (Rogaine)  
Monoclonal antibodies  
Nutritional supplements<sup>1</sup>  
Propoxyphene  
Recombinant human growth hormone (HGH)  
Synthetic growth hormone  
Alirocumab (Praluent)  
Evolocumab (Repatha)  
Pyrimethamine (generic for Daraprim—*see prescribing guidelines*)

**EXAMPLES**

Rukobia (Under consideration)  
Cymbalta, Prozac, and Zyprexa  
Enbrel  
Botox, Myobloc

Hyalgan, Synvisc Sandoglobulin,  
Venoglobulin Lioresal

Remicade, Synagis

Ensure  
Geref, Humatrope

**Class Exclusions**

Durable Medical Equipment<sup>2</sup>  
Cosmetic Medications  
Erectile Dysfunction Pharmaceuticals  
Female Sexual Dysfunction Pharmaceuticals  
Fertility Drugs  
Herbal Medications  
Vaccines/Immunizing Biologicals  
Weight Loss Medications

**Examples**

Test strips; Lancet, Meters, canes  
  
Viagra, Levitra, Cialis, Caverject  
  
Addyi (flibanserin)  
  
Zostavax  
Saxenda

All Controlled Substances (C-II, C-III, C-IV, and C-V) are EXCLUDED with the exception of the following:

- Anabolic steroids used to treat testosterone deficiencies (depo-testosterone, Aveed, Axiron, Oxandrolone, etc.)
- Anti-Diarrheals (Lomotil, diphenoxylate/atropine)
- Orexigenic (Marinol, Dronabinol)

**All medications must be order/shipped through IDPH's contracted pharmacy.**

<sup>1</sup> Vitamins (based on availability of State General Revenue Funds) and pain relievers (i.e. ibuprofen), sharps container, alcohol wipes and band aids are covered when prescribed by a physician. All other OTCs will be excluded.

<sup>2</sup> Syringes are covered for insulin injection only.

## PRESCRIBING GUIDELINES

Drugs provided by the Medication Assistance Program (MAP), also known as the AIDS Drug Assistance Program (ADAP) **MUST** be prescribed in accordance with these guidelines. Revisions to prescribing guidelines may be made upon recommendations of either the Department's Medical Director, HIV/AIDS Section Chief, or the ADAP Medical Issues Advisory Committee.

**All medications must be ordered/shipped through the Department's contracted dispensing pharmacy.**

1. Anti-retroviral therapies should be prescribed in accordance with the latest Public Health Service guidelines. <http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>
2. All newly FDA approved anti-retroviral therapies will be considered for addition to the formulary **after** the ADAP Medical Issues Advisory Committee has negotiated price on the medication. Please reference the ADAP Open Formulary Exclusions for the most current program exclusions (<https://iladap.providecm.net>).
3. **ALL** prescriptions for multi-source drugs (drugs available in a brand-name and equal or greater than one generic formulation) will be filled with the lowest cost option available. Use of brand namedrugs on the ADAP formulary is for informational purposes only.
  - a. For coverage under ADAP, prescriptions for multi-source drugs should be written indicating "**product substitution permitted**" to ensure all efforts for fiscal stewardship are able to be implemented by ADAP through its contracted dispensing pharmacy. In addition, this procedure will reduce the number of call-backs to prescribers by the dispensing pharmacy.
4. All prescriptions must be written for refills to follow the industry standard. However, prescriptions and refills should not supersede the client's ADAP eligibility period.
5. HIV co-receptor (CCR5 and/or CXCR4) tropism assay must be run and submitted to ADAP prior to prescribing Selzentry.
6. Egrifta requires a "Statement of Medical Necessity" to be filled out and faxed to the Manufacturer to get an Authorization code to be given to ADAP for our contracted pharmacy to dispense the medication. Statement of Medical Necessity form is attached.
7. Ritonavir (Norvir) tablets will be dispensed unless other formations are required by the prescriber due to tolerance issues. ADAP may require prior approval for other formulations.
8. Daraprim dispenses are restricted to **NDC 69413-0330-10**. Any other Daraprim NDC and the generic Pyrimethamine will not be approved by the Department and ***are specifically excluded***.

**PRESCRIBING GUIDELINES (cont'd)**

9. Eli Lilly’s products: The Department has successfully negotiated and received approval from the drug company to accept our Contract Pharmacy to dispense the NDC’s listed below. Please be mindful that all other Eli Lilly drug portfolio are excluded from Illinois ADAP Formulary, however generics are allowed as they are manufactured by other drug manufacturers.

<b>Applicable NDCs</b>	<b>Brand Name</b>	<b>Product Description</b>
00002-7510-01	HUMALOG	HUMALOG 100UCD 10.000000 MML
00002-7510-17	HUMALOG	HUMALOG 100UCD 3 MILLILITER
00002-7516-59	HUMALOG	HUMALOG CARTRIDGE 100UCD 15.000000 MML
00002-7714-59	HUMALOG	HUMALOG JR KWIKPEN 100UCD 15 MILLILITER
00002-8799-59	HUMALOG	HUMALOG KWIKPEN 100UCD 15 MILLILITER
00002-7511-01	HUMALOG	HUMALOG MIX 75/25 100UCD 10 MILLILITER
00002-7512-01	HUMALOG	HUMALOG MIX50/50 100UCD 10 MILLILITER
00002-8798-59	HUMALOG	HUMALOG MIX50/50 KWIKPEN 100UCD 15 MILLILITER
00002-8797-59	HUMALOG	HUMALOG MIX75/25 KWIKPEN 100UCD 15 MILLILITER
00002-8824-27	HUMULIN R U500	HUMULIN 500 UCD 6.000000 MILLILITER
00002-8501-01	HUMULIN R U500	HUMULIN R 500UCD 20 MILLILITER
00002-7737-01	INSULIN LISPRO	INSULIN LISPRO 100 UCD 10.000000MILLILITER
00002-7752-05	INSULIN LISPRO	INSULIN LISPRO KWIKPEN JR 100UCD 15 MILLILITER
00002-8222-59	INSULIN LISPRO	INSULIN LISPRO KWIKPEN 100UCD 15.000000 MILLILITER
00002-8233-05	INSULIN LISPRO	INSULIN LISPROMIX75/25 KWIKPEN 100UCD 15 MILLILITER
66733-0773-01	INSULIN LISPRO	INSULIN LISPRO 100 UCD 10.000000 MILLILITER
66733-0822-59	INSULIN LISPRO	INSULIN LISPRO 100 UCD 15.000000 MILLILITER

### **PRIOR APPROVALS**

1. The following drugs will require prior approval from the Department. All prior approval applications, including eligibility criteria and requirements, can be found at <https://iladap.providecm.net>.
  - a. **Atovaquone (Mepron)** requires prior approval in all of the following situations:
    - i. Used for more than 21 days.
    - ii. Used as prophylaxis rather than treatment
    - iii. More than one prescription per year is written for a patient not approved for use of Atovaquone as prophylaxis.
  - b. **Enfurvitide (Fuzeon)** is limited to a cap of 15 clients concurrently. Eligibility is based on the following medical criteria:
    - i. Failure of the current HAART regimen.
    - ii. CD4 count less than 500
    - iii. Viral load greater than 500.
  - c. **Valganciclovir (Valcyte)** oral only, limited to a cap of 35 clients concurrently. Must meet one of the following:
    - i. Prescribed for induction or maintenance treatment of cytomegalovirus (CMV) retinitis, or
    - ii. Prescribed for a condition other than retinitis that is due to CMV.
  - d. **Ibalizumab-uiyk (Trogarzo)** requires pre-approval from the Department, as well as the attached Manufacturer's Enrollment Form. Trogarzo is limited to a cap of 20 clients concurrently. The Department encourages clients to be dually enrolled in RWPB Case Management for payment of Trogarzo infusion costs.
    - i. Eligible patients must have a history of multi-drug resistant HIV infection.
    - ii. Trogarzo must be shipped directly to a medical facility/infusion site.
  - e. **Hepatitis C** prior approval medications include:
    - i. Harvoni (ledipasvir/sofosbuvir), Viekira Pak, Sovaldi (sofosbuvir), Ribavirin, Zepatier, Technivie, Daklinza, Eplclusa, Vosevi, Mavyret
    - ii. Hepatitis C prior approvals require documentation of baseline HCV RNA, HCV Genotype, and Fibrosis Staging. Zepatier also requires baseline NS5A resistance testing if Genotype 1a.
    - iii. Physicians must review the Manufacturer's prescribing Guidelines for possible drug interactions and issues associated with the Hepatitis C medication regimen they are prescribing in conjunction with their client's current HIV regimen.
  - f. **Serostim** may be prescribed for treatment of HIV associated wasting only and requires a prior approval. The Program has implemented a cap of 15 clients concurrently.
  - g. **Hormone Therapy.** The following medications are available with prior approval for clients who are currently in the process of gender transition, or in the maintenance stage from gender transition:
    - i. Estradiol, Finasteride, Progestin, Spironolactone
    - ii. Guidance references for primary care protocol for hormone treatment for gender transition and maintenance:
      1. The Center for Excellence for Transgender Health—*Primary Care Protocol—Hormone Administration*: <http://transhealth.ucsf.edu/trans?page=protocol-hormones>
      2. The World Professional Association for Transgender Health—Standards of Care: <http://www.wpath.org/publications/soc>