Illinois Department of Public Health
Ryan White Part B Program
Medication Assistance Program Formulary
Effective 7/8/2024
P: 888-311-7685 www.ramsellcorp.com F: 800-848-4241

| Coverage I = include E = exclude ^ = PA drug | ITEM Name | GENERIC NAME | BRAND NAME | RESTRICTION or NOTES |
|---|---|---|---|---|
| I | ALL | ALL | ALL | |
| | Note: ALL PRESCRIPTION DRUGS are covered with noted prior authorizations and exclusions listed below. See bottom of this document for all PRESCRIBING GUIDELINES and PROGRAM FORMULARY details that includes detailed PA requirements. | | | |
| | **PRIOR APPROVAL DRUGS:** | | Review detailed PA requirements on individual forms posted on website or in the Prescribing Guidelines at end of document.. | |
| **Coverage I = include E = exclude ^ = PA drug** | **ITEM Name** | **GENERIC NAME** | **BRAND NAME** | **RESTRICTION or NOTES** |
| I^ | | atovaquone susp | Mepron | See detailed PA criteria |
| I | | finasteride | Proscar 5mg | Allow for prostate disorders only (BPH). No PA Supplemental Form required effective 7.8.24 |
| I^ | | ibalizumab-uiyk | Trogarzo | Manufacturers enrollment form also required, 20 client cap |
| I^ | | lenacapavir sodium | Sunlenca | Drug accessible ONLY at CVS SPECIALITY Monroeville. Phone: 800-238-7828 Fax: 888-604-0385. See detailed PA criteria |
| I^ | | maraviroc | Selzentry | Tropism assay results required for PA determination. |
| I | | sildenafil | Viagra | Allow for PAH diagnosis only. Optionally dispense sildenafil 20mg (Revatio) for PAH with no PA required. No PA Supplemental Form required effective 7.8.24 |

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| I | | tadalafil | Cialis | Allow for PAH diagnosis (20mg tab only) Optionally dispense tadalafil (PAH) 20mg (Adcirca) with no PA required.No PA Supplemental Form required effective 7.8.24 |
| | Recombinant human growth hormone | | Brand Name | Cap of 15 clients concurrently |
| I | | Somatropin | Serostim 4mg | Coverage is restricted to treatment of HIV associated wasting only. No PA Supplemental Form required effective 7.8.24 |
| I | | Somatropin | Serostim 5mg | |
| I | | Somatropin | Serostim 6mg | |
| | | | Brand Name | |
| I | | valganciclovir | Valcyte, oral only | No PA Supplemental Form required effective 8/1/22. Cap of 35 clients concurrently |

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| | **SPECIFIC EXCLUSIONS** | **GENERIC NAME** | **BRAND NAME** | |
| E | Botulinum toxin | botulinum toxin A; B | Botox, Myobloc | |
| E | Compounded Medications for infusion | | | Active medication containing more than one ingredient |
| E | Gonadotropin (GnRH Antagonist) | degarelix (inj) | Firmagon | |
| E | Gonadotropin (GnRH Antagonist) | reluegoelix (po) | Orgovyx | |
| E | Hyaluronic acid derivatives | hyaluronic acid derivatives | | |
| E | Immune globulin intravenous (IGIV) | Immune globulin intravenous (IGIV) | Gammagard, Octagam | |
| | | | | |
| E | | mifepristone | Mifeprex, Korlym | |
| E | | minoxidil | Rogaine | |
| E | Monoclonal antibody, TNF-alpha blocker - inflammatory bowel agent | inFLIXimab | Remicade | |
| E | Monoclonal antibody | palivizumab | Synagis | |
| E | Recombinant human growth hormone (HGH)/Synthetic Growth Hormone | somatropin | | |
| I^ | | *somatropin* | *Serostim* | Exception |
| E | PCSK9 inhibitor | alirocumab | Praluent | |
| E | PCSK9 inhibitor | evolocumab | Repatha | |
| | | | | |
| E | | pyrimethamine | Daraprim | **Single NDC exception allowed as listed below.** |
| I | | *pyrimethamine* | *Daraprim* | NDC: 69413-0330-10 |
| | **CLASS EXCLUSIONS** | | | |
| **E** | Antirheumatic injectables | | | |
| | TNF-alpha blockers | | | |
| | TNF-alpha blocker - monoclonal antibodies | | | |
| | antirheumatic antimetabolites | | | |
| **E** | Injectible Cardiovascular/Cardiac Drugs | | | |

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| | **CLASS EXCLUSIONS CONTINUED** | | | |
| | | | | |
| **E** | Cosmetic Medications | | | |
| | Glabellar lines agents | | | |
| | Acne Products | | | |
| | depigmenting agents | | | |
| **E** | Cosmetic Medications continued | | | |
| | Agents for wrinkles/lipoatrophy | | | |
| | Misc Topical Dermatologicals | | | |
| **E** | Durable Medical Equipment | | | |
| | | examples: test strips, lancets, meters, canes | | |
| | **Included durable medical equipment products are listed below. These are exceptions to the excluded DME agents.** | | | |
| I | | *alcohol swabs & wipes* | | |
| I | | *band aids* | | |
| I | | *insulin needles & syringes* | | |
| I | | *injection device for insulin* | | |
| I | | *needles & syringes for use with injectible Hormone Replacement Therapy only* | | Pre-requisite use of injectible HRT therapy required |
| I | | *pen needles* | | |
| I | | *sharps container* | | |
| **E** | Erectile Dysfunction Pharmaceuticals | | | |
| | | | | |
| **E** | Female Sexual Dysfunction Pharmaceuticals | | | |
| | | | | |
| **E** | Fertility Drugs | | | |
| | Ovulation stimulants | | | |
| | GnRH/LHRH antagonist | | | |
| **E** | Herbal Medications | | | |
| | | | | |
| **E** | Injectable Muscle Relaxants | | | |
| | | | | |
| **E** | Nutritional supplements | | | |
| | | | | |

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| **E** | OTCs | | | |
| | **Included OTC products are listed below. These are exceptions to the excluded OTC products.** | | | |
| I | Insulin | *insulin* | | |
| I | OTC Nicotine Replacement Therapy | *Nicotine TD Patch 24 HR Kit* | *Nicotine Transdermal System* | Effective 6/1/2022 |
| I | | *Nicotine TD Patch 24HR* | *Nicotine Transdermal System* | Effective 6/1/2022 |
| I | | *Nicotine Polacrilex Gum* | *Nicorette* | Effective 6/1/2022 |
| I | | *Nicotine Polacrilex Lozenge* | *Nicorette* | Effective 6/1/2022 |
| I | Specified Vitamins | *Prenatal vitamins* | | |
| I | | *Multivitamins* | | |
| I | | *Multivitamins w/ iron* | | |
| I | | *Multivitamins w/ minerals* | | |
| I | | *Calcium* | | |
| I | | *Iron* | | |
| I | | *Vitamin D analogs* | | |
| I | | *B Vitamins* | | |
| I | Specified OTC Analgesics Included | *aspirin, acetaminophen, ibuprofen* | | |
| **E** | Vaccines/Immunizing Biologicals | | | |
| | | | | |
| **E** | Weight Loss Medications | | | |
| | anti-obesity agents | | | |
| | anorexiants non-amphetamine | | | |
| **E** | C-II, C-III, CIV, CV controlled substances | | | |
| | **Included controlled substances are listed below. These are allowed exceptions.** | | | |
| I | *Anabolic Steroids* | *depo-testosterone* | *Aveed, Axiron* | |
| I | *Anabolic Steroids* | *oxandrolone* | | |
| I | *Anti-diarrheals* | *diphenoxylate/atropine* | *Lomotil* | |
| | | *dronabinol* | *Marinol* | |

**PRESCRIBING GUIDELINES**

Drugs provided by the Medication 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 ADAP Administrator, Medical Director, or HIV/AIDS Section Chief.

1. Anti-retroviral therapies should be prescribed in accordance with the Panel on antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at https://clinicalinfo.hiv.gov/en/guidelines

2. All newly FDA approved anti-retroviral therapies will be considered for addition to the formulary **after** the National ADAP Crisis Task Force Committee has negotiated price on the medication.

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| 3. Please reference the ADAP Open Formulary Exclusions for the most current program exclusions in Section 3 of this document and at http://www.ramsellcorp.com/pharmacies/ILInsured.aspx#Formulary | | | | |
| 4. **ALL** prescriptions for multisource 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 name drugs on the ADAP formulary is for informational purposes only.<br>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 pharmacies. In addition, this procedure will reduce the number of call-backs to prescribers by the dispensing pharmacy. | | | | |
| 5. 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. | | | | |
| 6. Daraprim dispensing is 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.*** | | | | |
| 7. Please note that Egrifta is no longer being manufactured. This product has been replaced by Egrifta SV. Egrifta SV is an approved drug and does not require a prior approval from IDPH. | | | | |
| 8. Effcetive 12/1/2023, Sunlenca has been added to the IL ADAP formulary with a prior authorization requirement and is accesible ONLY through CVS Specialty Pharmacy in Monroeville, PA. See PA form for details. CVS contact Information: Phone: 800-238-7828, Fax: 888-604-0385 | | | | |
| | | | | |

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| **PROGRAM FORMULARY** | | | | |
| 1. **ALL PRESCRIPTION DRUGS** are covered with noted prior authorizations and exclusions. | | | | |
| 2. The formulary includes commonly requested drug classes such as bisphosphonates for osteoporosis, hypertension drugs, and PAH drugs. The Illinois Department of Public Health reserves the right to exclude drugs that do not meet program budget requirements. | | | | |
| 3. PRIOR AUTHORIZATION (PA) REQUIRED DRUGS – The following drugs require prior approval. Prior authorizations are processed by Ramsell Corporation, the PBM service provider for the Illinois Department of Public Health. All prior approval forms, including eligibility criteria and requirements, can be found at http://www.ramsellcorp.com/pharmacies/ILInsured.aspx#PAForms | | | | |
| **a. Atovaquone Suspension (Mepron) -** requires prior approval in all of the following situations:<br>i. Used for more than 21 days<br>ii. Used as prophylaxis rather than treatment<br>iii. More than one prescription per year is written for a patient not approved for use of Atovaquone as prophylaxis | | | | |
| **b. Finasteride (Proscar 5mg) –** Diagnosis code required. Used for treatment of benign prostatic hyperplasia (BPH). No prior approval form is needed. | | | | |
| **c. Ibalizumab-uiyk (Trogarzo)** – requires pre-approval from Ramsell as well as the Manufacturer's Enrollment Form<br>i. Eligible patients must have a history of multi-drug resistant HIV infection.<br>ii. Trogarzo must be shipped directly to a medical facility/infusion site. | | | | |
| **d. Maraviroc (Selzentry) –** requires submission of HIV co-receptor (CCR5 and/or CXCR4) tropism assay results for pre-approval determination. | | | | |
| **e. Recombinant Human Growth Hormone (Serostim) -** Coverage is restricted to treatment of HIV associated wasting only and requires a prior approval. No prior approval form is needed. Confirm diagnosis code at point of sale. The program has a cap of 15 clients concurrently. | | | | |
| **f. Sildenafil (Viagra)** – Diagnosis code required. Coverage restricted to PAH diagnosis only. Optionally dispense sildenafil 20mg (Revatio) for PAH with no PA required. No prior approval form is needed. | | | | |
| **g. Sunlenca (Lenacapavir Sodium)** – Eligibility is based on the following medical criteria:<br>i. Drug is being used in combination with other antiretrovirals (ARVs)<br>ii. Used in heavily treatment-experienced adult with multidrug resistant HIV-1 infection<br>iii. Current viral load greater than 200 copies per mL | | | | |
| h. **Tadalafil (Cialis)** – Diagnosis code required. Coverage restricted to PAH diagnosis only. Optionally dispense sildenafil 20mg (Revatio) for PAH with no PA required. No prior approval form is needed. | | | | |