Illinois Department of Public Health
Ryan White Part B Program
Medication Assistance Program Formulary
Effective 7/9/2025
P: 888-311-7685 www.ramsellcorp.com F: 800-848-4241

Coverage I = include E = exclude ^ = PA drug DR = Diagnosis Required	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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Coverage I = include E = exclude ^ = PA drug DR = Diagnosis Required	ITEM Name	GENERIC NAME	BRAND NAME	RESTRICTION or NOTES
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
	DIAGNOSIS REQUIRED DRUGS:			
DR	GLP 1 Receptor Antagonist	Semaglutide Injectable	Ozempic	Diagnosis code required
DR	GLP 1 Receptor Antagonist	Tirzepatide	Mounjaro	Diagnosis code required

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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

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	CLASS EXCLUSIONS			
E	Antirheumatic injectables			
	TNF-alpha blockers			
	TNF-alpha blocker - monoclonal antibodies			
	antirheumatic antimetabolites			
E	Injectible Cardiovascular/Cardiac Drugs			
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			

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	CLASS EXCLUSIONS CONTINUED			
E	Injectable Muscle Relaxants			
E	Nutritional supplements			
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*	

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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.				
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. 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: 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. 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				
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.				
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:				
i. Drug is being used in combination with other antiretrovirals (ARVs)				
ii. Used in heavily treatment-experienced adult with multidrug resistant HIV-1 infection				
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.				
i. **Ozempic (Semaglutide Injectable), Mounjaro (tirzepatide)** – Effective 7/9/2025, a diagnosis code is required. Coverage is restricted to a Diabetes diagnosis only. No prior approval form is needed. Please note that GLP-1 receptor agonists used for weight management are non-formulary. Weight management drugs such as Wegovy (semaglutide) and Zepbound (tirzepatide) are still non-formulary drugs on the IL MAP Formulary.				