ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Ryan White Part B Program
Medication Assistance Program (ADAP) Formulary Summary & Prescribing Guidelines
7.9.2025

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, HIV/AIDS Section Chief, or the ADAP Medical Issues Advisory Committee.

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 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 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 This product has been replaced by Egrifta SV.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.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Ryan White Part B Program
Medication Assistance Program (ADAP) Formulary Summary & Prescribing Guidelines
7.9.2025

PROGRAM FORMULARY

1. **ALL PRESCRIPTION DRUGS** are covered with noted prior authorizations and exclusions.

2. Note: All drugs not identified as excluded are covered. 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 that can be accessed here: **https://theratechnologies.s3.amazonaws.com/prod/media/TROGARZO_Enrollment_Form.pdf.** 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. Criteria is as follows:
        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) - Diagnosis code required.** Coverage is restricted to treatment of HIV associated wasting only. No prior approval form is needed. 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)** – Drug accessible ONLY at CVS SPECIALITY Monroeville. Phone: 800-238-7828 Fax: 888-604-0385. 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 (20mg tab). Optionally dispense tadalafil (PAH) 20mg (Adcirca) with no PA required. No prior approval form is needed.
i. **Ozempic (Semaglutide Injectable)** – Effective 7/9/2025, a diagnosis code is required for coverage. Coverage is restricted to a Diabetes diagnosis only. No prior approval form is needed.

1. FORMULARY EXCLUSIONS

PLEASE NOTE: All FDA APPROVED HIV drugs are currently covered by the Program unless specifically indicated in the exclusions section below. For class exclusions, example drugs may be provided. Exceptions to the class exclusions are indicated in the notes column.

ITEM NAME	GENERIC NAME	BRAND NAME	NOTES
SPECIFIC EXCLUSIONS			
Botulinum toxin	botulinum toxin A; B	Botox, Myoblox	
Compounded Medications for infusion			Active medication containing more than one ingredient
Gonadotropin (GnRH Antagonist)	degarelix (inj)	Firmagon	
Gonadotropin (GnRH Antagonist)	reluegoelix (po)	Orgovyx	
Hyaluronic acid derivatives	hyaluronic acid derivatives		
Immune globulin intravenous (IGIV)	Immune globulin intravenous (IGIV)	Gammagard, Octagam	
	mifepristone	Mifeprex	
	mifepristone	Korlym	
	minoxidil	Rogaine	
TNF-alpha blocker - inflammatory bowel agent	inFLIXimab	Remicade	
Monoclonal antibodies	palivizumab	Synagis	
Recombinant human growth hormone (HGH)/Synthetic Growth Hormone	somatropin		
	alirocumab	Praluent	
	evolocumab	Repatha	
	pyrimethamine	Daraprim	
	pyrimethamine	*Daraprim*	*Include: 69413-0330-10*

ITEM NAME	GENERIC NAME	BRAND NAME	NOTES
CLASS EXCLUSIONS			
Antirheumatic injectables			
TNF-alpha blockers			
TNF-alpha blocker - monoclonal antibodies			
antirheumatic antimetabolites			
Injectable Cardiovascular/Cardiac Drugs			
Cosmetic Medications			
Glabellar lines agents			
Acne Products			
Pigmentation - dipigmenting agents			
Agents for wrinkles/lipoatrophy			
Durable Medical Equipment			
	ex. test strips, lancets, meters, canes		
Included durable medical equipment products are listed below. These are allowed exceptions:			
	alcohol swabs & wipes		*Include*
	band aids		*Include*
	insulin needles & syringes		*Include*
	injection device for insulin		*Include*
	needles & syringes for use with injectable hormone replacement therapy only		*Include - Prerequisite use of injectable HRT therapy required.*
	pen needles		*Include*
	sharps container		*Include*
Erectile Dysfunction Pharmaceuticals			
See prior authorization section for included ED drugs when used for pulmonary hypertension.			
Female Sexual Dysfunction Pharmaceuticals			
Fertility Drugs			
Ovulation stimulants			
GnRH/LHRH antagonist			
Herbal Medications			
Injectable Muscle Relaxants			

ITEM NAME	GENERIC NAME	BRAND NAME	NOTES
CLASS EXCLUSIONS CONTINUED			
Nutritional supplements			
OTCs			
Included OTC products are listed below. These are exceptions to the excluded OTC products.			
	insulin		*Include*
OTC Nicotine Replacement Therapy	*Nicotine TD Patch 24 HR Kit, Nicotine TD Patch 24HR, Nicotine Polacrilex Gum, Nicotine Polacrilex Lozenge*	*Nicotine Transdermal System, Nicorette*	*Include*
Specified Covered Vitamins	*Prenatal Vitamins, Multivitamins, Calcium, Iron, Vitamin D analogs, and B vitamins*		*Include*
Specified Covered OTC Analgesics	*aspirin, acetaminophen, ibuprofen*		*Include*
Vaccines/Immunizing Biologicals			
Weight Loss Medications			
C-II, C-III, CIV, CV controlled substances			
Included controlled substances are listed below. These are allowed exceptions.			
Anabolic Steroids	*depo-testosterone*	*Aveed, Axiron*	*Include*
Anabolic Steroids	*oxandrolone*		*Include*
Anti-diarrheals	*diphenoxylate/atropine*	*Lomotil*	*Include*
	dronabinol	*Marinol*	*Include*
MANUFACTURER EXCLUSION			
GlaxoSmithKline (GSK) products			The following labeler codes have been excluded from the IL MAP Uninsured formulary effective 7/1/2023: 99850, 00173, 49401 & 69656