



Illinois Department of Public Health
 Ryan White Part B Program
 Medication Assistance Program Formulary
 Effective 8/1/2022 v2



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^		enfuvirtide	Fuzeon	See detailed PA criteria. 15 client cap.
I^		finasteride	Proscar 5mg	Allow for prostate disorders only (BPH)
I^		ibalizumab-uiyk	Trogarzo	Manufacturers enrollment form also required, 20 client cap
I^		maraviroc	Selzentry	Tropism assay results required for PA determination.
I^		ritonavir oral soln	Norvir	Tablets covered without PA
I^		ritonavir powder packets	Norvir	Tablets covered without PA
I^		sildenafil	Viagra	Allow for PAH diagnosis only. Optionally dispense sildenafil 20mg (Revatio) for PAH with no PA required.
I^		tadalafil	Cialis	Allow for PAH diagnosis (20mg tab only) Optionally dispense tadalafil (PAH) 20mg (Adcirca) with no PA required.
Hepatitis C therapy				See detailed PA criteria
I^		elbasvir/grazoprevir	Zepatier	
I^		glecaprevir/pibrentasvir	Mavyret	



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	PRIOR APPROVAL DRUGS CONTINUED:			Review detailed PA requirements on individual forms posted on website or in the Prescribing Guidelines at end of document..
	Hepatitis C therapy continued			See detailed PA criteria
I^		ledipasvir/sofosbuvir	Harvoni	
I^		ombitasvir/paritaprevir/ ritonavir + dasabuvir	Viekira Pak	
I^		sofosbuvir	Sovaldi	
I^		sofosbuvir/velpatasvir	Epclusa	
I^		sofosbuvir/velpatasvir/voxilap revir	Vosevi	
I^		ribavirin		oral tab or cap
	Hormone therapy		Brand Name Examples	See detailed PA criteria. Submit all with PA form.
I^		estradiol	Estrace, Estrogel, Minivelle, etc	
I^		estradiol	Delestrogen (inj)	
I^		estradiol	Estrace Vaginal Cream, Vagifem	
I^		finasteride	Propecia	
I^	Progestins	medroxyprogesterone	Depo-Provera (inj)	Inj
I^	Progestins	medroxyprogesterone	Provera	oral tabs
I^	Progestins	progesterone		IM, oral cap
I^	Progestins	progesterone	Crinone, Endometrin	Vag gel, supp, insert
	Recombinant human growth hormone		Brand Name	Cap of 15 clients concurrently
I^		Somatropin	Serostim 4mg	
I^		Somatropin	Serostim 5mg	
I^		Somatropin	Serostim 6mg	
			Brand Name	
I		valganciclovir	Valcyte, oral only	No PA Supplemental Form required effective 8/1/22
	SPECIFIC EXCLUSIONS	GENERIC NAME	BRAND NAME	
E	Antiretroviral Drug	cabotegravir/rilpivirine	Cabenuva	Currently under consideration for HIV treatment
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	



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SPECIFIC EXCLUSIONS				
CONTINUED				
		GENERIC NAME	BRAND NAME	
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^		<i>somatropin</i>	<i>Serostim</i>	Exception
E	PCSK9 inhibitor	alirocumab	Praluent	
E	PCSK9 inhibitor	evolocumab	Repatha	
E		pyrimethamine	Daraprim	Single NDC exception allowed as listed below.
I		<i>pyrimethamine</i>	<i>Daraprim</i>	NDC: 69413-0330-10
CLASS EXCLUSIONS				
E	Antirheumatic injectables			
	TNF-alpha blockers			
	TNF-alpha blocker - monoclonal antibodies			
	antirheumatic antimetabolites			
E	Injectible Cardiovascular/Cardiac Drugs			
E	Cosmetic Medications			
	Glabella lines agents			
	Acne Products			
	depigmenting agents			



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	CLASS EXCLUSIONS CONTINUED			
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		<i>alcohol swabs & wipes</i>		
I		<i>band aids</i>		
I		<i>insulin needles & syringes</i>		
I		<i>injection device for insulin</i>		
I		<i>pen needles</i>		
I		<i>sharps container</i>		
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			
E	OTCs			
	Included OTC products are listed below. These are exceptions to the excluded OTC products.			
I	Insulin	<i>insulin</i>		
I	OTC Nicotine Replacement Therapy	<i>Nicotine TD Patch 24 HR Kit</i>	<i>Nicotine Transdermal System</i>	Effective 6/1/2022
I		<i>Nicotine TD Patch 24HR</i>	<i>Nicotine Transdermal System</i>	Effective 6/1/2022
I		<i>Nicotine Polacrilex Gum</i>	<i>Nicorette</i>	Effective 6/1/2022
I		<i>Nicotine Polacrilex Lozenge</i>	<i>Nicorette</i>	Effective 6/1/2022



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I	Specified Vitamins	<i>Prenatal vitamins</i>		
I		<i>Multivitamins</i>		
I		<i>Multivitamins w/ iron</i>		
I		<i>Multivitamins w/ minerals</i>		
I		<i>Calcium</i>		
I		<i>Iron</i>		
I		<i>Vitamin D analogs</i>		
I		<i>B Vitamins</i>		
I	Specified OTC Analgesics Included	<i>aspirin, acetaminophen, ibuprofen</i>		
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	<i>Anabolic Steroids</i>	<i>depo-testosterone</i>	<i>Aveed, Axiron</i>	
I	<i>Anabolic Steroids</i>	<i>oxandrolone</i>		
I	<i>Anti-diarrheals</i>	<i>diphenoxylate/atropine</i>	<i>Lomotil</i>	
		<i>dronabinol</i>	<i>Marinol</i>	

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>



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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. Ritonavir (Norvir) tablets will be dispensed unless other formulations are required by the prescriber due to tolerance issues. ADAP may require prior approval for other formulations.

7. 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**.

8. 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.

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. Enfuvirtide (Fuzeon)** – limited to a cap of 15 clients concurrently. Eligibility is based on the following medical
- i. Failure of the current HAART regimen
 - ii. CD4 count less than 500
 - iii. Viral load greater than 500

c. Finasteride (Proscar 5mg) – used for treatment of benign prostatic hyperplasia (BPH)



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	<p>d. Hepatitis C Drugs - Treatment guidelines found at https://hcvguidelines.org/</p> <p>Criteria</p> <ol style="list-style-type: none"> 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. 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. 			
	<p>e. Hormone Therapy</p> <ol style="list-style-type: none"> Available with prior approval for clients who are currently in the process of gender transition, or in the maintenance stage from gender transition. <p>Guidance references for primary care protocol for hormone treatment for gender transition and maintenance:</p> <ol style="list-style-type: none"> The Center for Excellence for Transgender Health-Primary Care Protocol-Hormone Administration: The World Professional association for Transgender Health – Standards of Care: 			
	<p>f. Ibalizumab-uiyk (Trogarzo) – requires pre-approval from Ramsell as well as the Manufacturer’s Enrollment</p> <ol style="list-style-type: none"> Eligible patients must have a history of multi-drug resistant HIV infection. Trogarzo must be shipped directly to a medical facility/infusion site. 			
	<p>g. Maraviroc (Selzentry) – requires submission of HIV co-receptor (CCR5 and/or CXCR4) tropism assay results for pre-approval determination.</p>			
	<p>h. Recombinant Human Growth Hormone (Serostim) - Coverage is restricted to treatment of HIV associated wasting only and requires a prior approval. The program has a cap of 15 clients concurrently.</p>			
	<p>i. Sildenafil (Viagra) – Coverage restricted to PAH diagnosis only. Optionally dispense sildenafil 20mg (Revatio) for PAH with no PA required.</p>			
	<p>j. Tadalafil (Cialis) – Coverage restricted to PAH diagnosis only (20mg tab). Optionally dispense tadalafil (PAH) 20mg (Adcirca) with no PA required.</p>			