2024

Step Therapy Protocols

- Imperial Senior Value (HMO C-SNP) 005
- Imperial Traditional (HMO) 007
- Imperial Dual Plan (HMO D-SNP) 011
- Imperial Dynamic Plan (HMO) 012
- Imperial Strong (HMO) 014

IMPERIAL HEALTH PLAN
OF CALIFORNIA

STEP THERAPY PROGRAMS

How do I request an exception to the Imperial Health Plan of California (HMO) (HMO SNP)?

You can ask Imperial Health Plan of California (HMO) (HMO SNP) to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, being required to first try certain drugs to treat your medical condition before we will cover another drug for that condition or generic version of a drug instead of the original brand name drug.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. "Also, you may not ask us to provide a higher level of coverage for drugs that are in the specialty tier."

Generally, Imperial Health Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

Your physician must submit a statement supporting your coverage determination or exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

What if I have additional questions?

You can call us at: 1-**877-391-1105** (seven days a week, 24 hours a day) if you have any additional questions. If you have a hearing or speech impairment, please call us at TTY 711.

IR_420 H5496 ST Program_C ENG 11/06/23

ANTICONVULSANTS

Products Affected

Step 2:

- APTIOM 200 MG TABLET
- APTIOM 400 MG TABLET
- APTIOM 600 MG TABLET
- APTIOM 800 MG TABLET
- DILANTIN 30 MG CAPSULE
- FYCOMPA 0.5 MG/ML ORAL SUSPENSION
- FYCOMPA 10 MG TABLET
- FYCOMPA 12 MG TABLET
- FYCOMPA 2 MG TABLET
- FYCOMPA 4 MG TABLET
- FYCOMPA 6 MG TABLET
- FYCOMPA 8 MG TABLET
- SPRITAM 1,000 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 250 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 500 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 750 MG TABLET FOR ORAL SUSPENSION
- SYMPAZAN 10 MG ORAL FILM
- SYMPAZAN 20 MG ORAL FILM
- SYMPAZAN 5 MG ORAL FILM
- VALTOCO 10 MG/SPRAY (0.1 ML) NASAL SPRAY
- VALTOCO 15 MG/2 SPRAY(7.5MG/0.1ML X2) NASAL SPRAY
- VALTOCO 20 MG/2 SPRAY (10MG/0.1ML X2) NASAL SPRAY
- VALTOCO 5 MG/SPRAY (0.1 ML) NASAL SPRAY

Details

Criteria	Claim will pay automatically if enrollee has a paid claim for at least a 1 day supply of a generic formulary anticonvulsant in the past 365 days. Otherwise, a step therapy exception request will be required indicating: (1) history of inadequate treatment response with a generic formulary anticonvulsant, (2) history of adverse event with a generic formulary anticonvulsant, or (3) generic formulary anticonvulsants are contraindicated.

ANTIDEPRESSANTS

Products Affected

Step 2:

- AUVELITY 45 MG-105 MG TABLET, EXTENDED RELEASE
- EMSAM 12 MG/24 HR TRANSDERMAL 24 HOUR PATCH
- EMSAM 6 MG/24 HR TRANSDERMAL 24 HOUR PATCH
- EMSAM 9 MG/24 HR TRANSDERMAL 24 HOUR PATCH
- MARPLAN 10 MG TABLET
- TRINTELLIX 10 MG TABLET
- TRINTELLIX 20 MG TABLET
- TRINTELLIX 5 MG TABLET

Details

Criteria	Claim will pay automatically if enrollee has a paid claim for at least a 1 day supply of any generic formulary antidepressant in the past 365 days. Otherwise, a step therapy exception request will be required indicating: (1) history of inadequate treatment response with a generic formulary antidepressant, (2) history of adverse event with a generic formulary antidepressant, or (3) generic formulary antidepressants are contraindicated.

ATYPICALS

Products Affected

Step 2:

- FANAPT 1 MG TABLET
- FANAPT 10 MG TABLET
- FANAPT 12 MG TABLET
- FANAPT 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLETS IN A DOSE PACK
- FANAPT 2 MG TABLET
- FANAPT 4 MG TABLET
- FANAPT 6 MG TABLET
- FANAPT 8 MG TABLET
- LYBALVI 10 MG-10 MG TABLET
- LYBALVI 15 MG-10 MG TABLET
- LYBALVI 20 MG-10 MG TABLET
- LYBALVI 5 MG-10 MG TABLET
- SECUADO 3.8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH
- SECUADO 5.7 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH
- SECUADO 7.6 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH
- VERSACLOZ 50 MG/ML ORAL SUSPENSION
- VRAYLAR 1.5 MG (1)-3 MG (6) CAPSULES IN A DOSE PACK
- VRAYLAR 1.5 MG CAPSULE
- VRAYLAR 3 MG CAPSULE
- VRAYLAR 4.5 MG CAPSULE
- VRAYLAR 6 MG CAPSULE
- ZYPREXA RELPREVV 210 MG IM SUSPENSION

Details

Criteria	Claim will pay automatically if enrollee has a paid claim for at least a 1 day supply of 2 generic formulary agents in the past 365 days. Otherwise, a step therapy exception request will be required indicating: (1) diagnosis that is not covered by 2 generic formulary agents, (2) history of inadequate treatment response with 2 generic formulary agents, (3) history of adverse event with 2 generic formulary agents, or (4) 2 generic formulary agents are contraindicated.

RYTARY

Products Affected

Step 2:

- RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE
- RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE
- RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE
- RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE

Details

Criteria	Claim will pay automatically if enrollee has a paid claim for at least a 1 day supply of generic Carbidopa, Carbidopa/Levodopa, or Carbidopa/Levodopa/Entacapone in the past 365 days. Otherwise, Rytary requires a step therapy exception request indicating: (1) history of inadequate treatment response with Carbidopa, Carbidopa/Levodopa, or Carbidopa/Levodopa/Entacapone, (2) history of adverse event with Carbidopa, Carbidopa/Levodopa, or Carbidopa/Levodopa/Entacapone, or (3) Carbidopa, Carbidopa/Levodopa, or Carbidopa/Levodopa/Entacapone is contraindicated.

INDEX