Effective Date: 5/1/2020
Last Reviewed: 5/2020, 2/2021. 3/2021, 5/2021, 6/2021, 10/2021, 12/2021, 1/2022, 2/2022, 2/2023, 09/2023, 01/2024, 05/2024 Scope: Medicaid

Medications Covered under the Pharmacy Benefit Only

PURPOSE: To identify medications that are only covered through the member's pharmacy benefit. The medications listed below will be covered with prior authorization when clinical criteria is met under the pharmacy benefit.

Members and providers will receive a 60-day advance notification of the change in benefit coverage if the member has obtained the medication under the medical benefit within the previous 180 days.

SCOPE: Medicaid

POLICY STATEMENT:

1. **The following pharmaceutical products are covered and available exclusively on the Pharmacy Benefit:**
    a. **Firazyr (icatibant)**
    b. **Dupixent (dupilumab)**
    c. **Botulinum toxin Products: Botox, Daxxify, Dysport, Myloboc and Xeomin**
    d. **Lumizyme (alglucosidase alfa)**
    e. **Somatuline Depot (lanreotide acetate)**
    f. **Nexviazyme (avalglucosidase alfa-ngpt)**
    g. **Tepezza (teprotumumab)**

References:

1. NHPRI Formulary Management Policy and Procedure