Specialty Pharmacy Drug List

The Specialty Drug List applies to Members that have a "Specialty Drug Tier" under their pharmacy benefit. Check Plan documents for your benefits. Drugs indicated with a (SP) are required to be obtained from a Health Net contracted Specialty Pharmacy and are not available out of network, through Mail Order, or for an extended days supply.

SPECIALTY DRUGS		
Arthritis / Psoriasis		
Brand	**Generic Name**	**Comments**
ACTEMRA 162MG SYRINGE (N)	TOCILIZUMAB SUB Q	PRIOR AUTHORIZATION REQUIRED
ENBREL (N)	ETANERCEPT	PRIOR AUTHORIZATION REQUIRED
HUMIRA (N)	ADALIMUMAB	PRIOR AUTHORIZATION REQUIRED
CIMZIA (EST) (N)	CERTOLIZUMAB PEGOL	PRIOR AUTHORIZATION REQUIRED
KINERET (EST) (N)	ANAKINRA	PRIOR AUTHORIZATION REQUIRED
METHOTREXATE (N)	METHOTREXATE	PRIOR AUTHORIZATION REQUIRED
ORENCIA SUB Q 125MG/ML (N)	ABATACEPT	PRIOR AUTHORIZATION REQUIRED
OTEZLA TABLETS (N)	APREMILAST	PRIOR AUTHORIZATION REQUIRED
SIMPONI (N)	GOLIMUMAB	PRIOR AUTHORIZATION REQUIRED
XELJANZ TABLETS (PA) (QL)	TOFACITINIB	PRIOR AUTHORIZATION REQUIRED
Blood Modifiers		
Brand	**Generic Name**	**Comments**
ARANESP (EST) (N)	DARBEPOETIN ALFA-ALBUMIN	PRIOR AUTHORIZATION REQUIRED
EPOGEN (EST) (N)	EPOETIN ALFA	PRIOR AUTHORIZATION REQUIRED
GRANIX (EST (N)	TBO-FILGRASTIM	PRIOR AUTHORIZATION REQUIRED
MIRCERA (N)	Methoxy Polyethylene Glycol-Epoetin Beta Injection	PRIOR AUTHORIZATION REQUIRED
NEULASTA (EST) (N)	PEGFILGRASTIM	PRIOR AUTHORIZATION REQUIRED
NEUMEGA (N)	OPRELVEKIN	PRIOR AUTHORIZATION REQUIRED
NEUPOGEN (N)	FILGRASTIM	PRIOR AUTHORIZATION REQUIRED
PROCRIT (N)	EPOETIN ALFA	PRIOR AUTHORIZATION REQUIRED
Blood Thinners		
Brand	**Generic Name**	**Comments**
ARIXTRA (N)	FONDAPARINUX SODIUM	PRIOR AUTHORIZATION REQUIRED-QUANTITY LIMITATIONS
FRAGMIN (N)	DALTEPARIN SODIUM	PRIOR AUTHORIZATION REQUIRED-QUANTITY LIMITATIONS
LOVENOX (N)	ENOXAPARIN SODIUM	PRIOR AUTHORIZATION REQUIRED-QUANTITY LIMITATIONS

Bolded Drugs are Preferred Drugs
EST = Stepped Therapy
N=Not Avilable Through Mail Order

Specialty Pharmacy Drug List

MULTIPLE SCLEROSIS DRUGS		
Brand	**Generic Name**	**Comments**
AVONEX (N)	INTERFERON BETA-1A	PRIOR AUTHORIZATION REQUIRED
AUBAGIO TABLETS (N) (LD)	TERIFLUNOMIDE	PRIOR AUTHORIZATION REQUIRED
BETASERON (N)	INTERFERON BETA-1B	PRIOR AUTHORIZATION REQUIRED
COPAXONE (N)	GLATIRAMER ACETATE	PRIOR AUTHORIZATION REQUIRED
EXTAVIA (N)	INTERFERON BETA-1B	PRIOR AUTHORIZATION REQUIRED
GILENYA CAPSULES (N)	FINGOLIMOD	PRIOR AUTHORIZATION REQUIRED
GLATOPA INJECTION (N)	GLATIRAMER ACETATE	PRIOR AUTHORIZATION REQUIRED
PLEGRIDY (N)	PEG-INTERFERON BETA-1A	PRIOR AUTHORIZATION REQUIRED
REBIF (N)	INTERFERON BETA-1A	PRIOR AUTHORIZATION REQUIRED
TECFIDERA CAPSULES (N)	DIMETHYL FUMARATE DELAYED RELEASE	PRIOR AUTHORIZATION REQUIRED
Growth Hormones		
Brand	**Generic Name**	**Comments**
HUMATROPE (N)	SOMATROPIN	PRIOR AUTHORIZATION REQUIRED
INCRELEX (N)	MECASERMIN	PRIOR AUTHORIZATION REQUIRED
NORDITROPIN (N)	SOMATROPIN	PRIOR AUTHORIZATION REQUIRED
SEROSTIM (N)	SOMATROPIN	PRIOR AUTHORIZATION REQUIRED
SOMAVERT (N)	PEGVISOMANT	PRIOR AUTHORIZATION REQUIRED
ZORBTIVE (N)	SOMATROPIN	PRIOR AUTHORIZATION REQUIRED
Migraine Medications		
Brand	**Generic Name**	**Comments**
SUMITRIPTAN INJ / SYRINGE (N)	SUMITRIPTAN	PRIOR AUTHORIZATION REQUIRED-QUANTITY LIMITATIONS
IMITREX INJ / SYRINGE (N)	SUMITRIPTAN	PRIOR AUTHORIZATION REQUIRED-QUANTITY LIMITATIONS
D.H.E. 45 (N)	DIHYDROERGOTAMINE	PRIOR AUTHORIZATION REQUIRED-QUANTITY LIMITATIONS
DIHYDROERGOTAMINE (N)	DIHYDROERGOTAMINE	PRIOR AUTHORIZATION REQUIRED-QUANTITY LIMITATIONS

Bolded Drugs are Preferred Drugs
EST = Stepped Therapy
N=Not Avilable Through Mail Order

rev: 10/1/15
Subject to change

Specialty Pharmacy Drug List

Osteoporosis Treatment		
Brand	**Generic Name**	**Comments**
FORTEO (N)	TERIPARATIDE (RECOMBINANT)	PRIOR AUTHORIZATION REQUIRED
MIACALCIN (N)	CALCITONIN (SALMON)	PRIOR AUTHORIZATION REQUIRED
Antivirals / Immune System Enhancers		
Brand	**Generic Name**	**Comments**
ACTIMMUNE (N)	INTERFERON GAMMA-1B	PRIOR AUTHORIZATION REQUIRED
DAKLINZA (N)	DACLATASVIR DIHYDROCHLORIDE	PRIOR AUTHORIZATION REQUIRED
FUZEON (N)	ENFUVIRTIDE	PRIOR AUTHORIZATION REQUIRED
HARVONI TABLETS (N)	TELAPREVIR	PRIOR AUTHORIZATION REQUIRED
INFERGEN (N)	INTERFERON ALFACON-1	PRIOR AUTHORIZATION REQUIRED
INTRON-A (N)	INTERFERON ALFA-2B	PRIOR AUTHORIZATION REQUIRED
OLYSIO CAPSULES (N)	SIMEPREVIR	PRIOR AUTHORIZATION REQUIRED
PEGASYS (N)	PEGINTERFERON ALFA-2A	PRIOR AUTHORIZATION REQUIRED
PEG-INTRON (N)	PEGINTERFERON ALFA-2B	PRIOR AUTHORIZATION REQUIRED
SOVALDI TABLETS (N)	SOFOSBUVIR	PRIOR AUTHORIZATION REQUIRED
TECHNIVIE TABLETS (N)	OMBITASVIR-PARITAPREVIR-RITONAVIR	PRIOR AUTHORIZATION REQUIRED
VIEKIRA PAK (N)	OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR	PRIOR AUTHORIZATION REQUIRED
VICTRELIS CAPSULES (N)	BOCEPREVIR	PRIOR AUTHORIZATION REQUIRED
Miscellaneous Sel-Injectable Drugs		
Brand	**Generic Name**	**Comments**
ALFERON N (N)	INTERFERON ALFA-N3	PRIOR AUTHORIZATION REQUIRED
APOKYN (N)	APOMORPHINE	PRIOR AUTHORIZATION REQUIRED
ARCALYST (N)	RILONACEPT	PRIOR AUTHORIZATION REQUIRED
AUVI-Q (QL) (PA) (N)	EPINEPHRINE	PRIOR AUTHORIZATION REQUIRED
CERDELGA (PA) (N) (LD)	ELIGLUSTAT TARTRATE	PRIOR AUTHORIZATION REQUIRED
EPIPEN , EPIPEN JR. (QL) (PA) (N)	EPINEPHRINE	PRIOR AUTHORIZATION REQUIRED
ESBRIET CAPSULES (N)	PIRFENIDONE	PRIOR AUTHORIZATION REQUIRED
GLUCAGEN (QL) (PA) (N)	GLUCAGON HCL (RDNA)	PRIOR AUTHORIZATION REQUIRED
GLUCAGON (QL) (PA) (N)	GLUCAGON (RDNA)	PRIOR AUTHORIZATION REQUIRED
LUPRON (N) - Not the Depot form	LEUPROLIDE ACETATE	PRIOR AUTHORIZATION REQUIRED
Octreotide (N) - Not the Depot form	OCTREOTIDE ACETATE	PRIOR AUTHORIZATION REQUIRED
OFEV CAPSULES (N)	NINTEDANIB ESYLATE	PRIOR AUTHORIZATION REQUIRED
PRALUENT INJECTION (N)	ALIROCUMAB	PRIOR AUTHORIZATION REQUIRED
RELISTOR (N)	METHYLNALTREXONE BROMIDE	PRIOR AUTHORIZATION REQUIRED
REPATHA INJECTION (N)	EVOLOCUMAB	PRIOR AUTHORIZATION REQUIRED
SANDOSTATIN (N) - Not the Depot / LAR form	OCTREOTIDE ACETATE	PRIOR AUTHORIZATION REQUIRED

Bolded Drugs are Preferred Drugs
EST = Stepped Therapy
N=Not Avilable Through Mail Order

Specialty Pharmacy Drug List

Drugs to treat Impotence (Not covered by all plans - check plan documents for coverage)		
Brand	**Generic Name**	**Comments**
CAVERJECT INJECTION (QL) (N)	ALPROSTADIL	PRIOR AUTHORIZATION REQUIRED-CHECK PLAN FOR COVERAGE
EDEX INJECTION (QL) (N)	ALPROSTADIL	PRIOR AUTHORIZATION REQUIRED-CHECK PLAN FOR COVERAGE
Drugs for the Treatment of Diabetes (non-insulin)		
BYDUREON (PA) (N)	EXENATIDE EXTENDED RELEASE	PRIOR AUTHORIZATION REQUIRED
BYETTA (PA) (N)	EXENATIDE	PRIOR AUTHORIZATION REQUIRED
SYMLIN (PA) (N)	PRAMLINTIDE ACETATE	PRIOR AUTHORIZATION REQUIRED
TANZEUM (PA) (N)	ALBIGLUTIDE	PRIOR AUTHORIZATION REQUIRED
TRULICITY (PA) (N)	DULAGLUTIDE	PRIOR AUTHORIZATION REQUIRED
VICTOZA (PA) (N)	LIRAGLUTIDE	PRIOR AUTHORIZATION REQUIRED
Antihemophilic Drugs (Check benefits for coverage)		
Brand	**Generic Name**	**Comments**
ADVATE (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [RECOMBINANT]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
ALPHANATE (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [HUMAN]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
ALPHANATE VWF (N)	VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR , PER I.U.	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
ALPHANINE SD (N)	FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-RECOMBINANT) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
ALPROLIX (N)	COAGULATION FACTOR IX (RECOMB) (RFIXFC)	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
BEBULIN VH (N)	FACTOR IX, COMPLEX, PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
BENEFIX (N)	FACTOR IX (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
CEPROTIN (N)	INJECTION, PROTEIN C CONCENTRATE, INTRAVENOUS, HUMAN, 10 IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
CORIFACT (N)	FACTOR XIII CONCENTRATE (HUMAN)	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
ELOCTATE (N)	ANTIHEMOPHILIC FACTOR (RECOMB) RFVIIIFC	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
FEIBA VH IMMUNO (ANTI-INHIBITOR COAGULANT COMPLEX) (N)	ANTI-INHIBITOR, PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
HELIXATE FS (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [RECOMBINANT]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
HEMOFIL M (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [HUMAN]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
HUMATE-P (N)	VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR, PER IU, VWF:RCO	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
IXINITY (N)	COAGULATION FACTOR IX (RECOMBINANT)	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
KCENTRA (N)	PROTHROMBIN COMPLEX CONC HUMAN	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
KOATE-DVI (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [HUMAN]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
KOGENATE FS (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE

Bolded Drugs are Preferred Drugs
EST = Stepped Therapy
N=Not Avilable Through Mail Order

rev: 10/1/15
Subject to change

Specialty Pharmacy Drug List

Brand	Generic Name	Comments
MONOCLATE-P (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [HUMAN]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
MONONINE (N)	FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-RECOMBINANT) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
NOVOSEVEN (N)	FACTOR VIIA (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PER 1 MICROGRAM	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
NOVOEIGHT (N)	ANTIHEMOPHILIC FACTOR (RECOMB)	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
OBIZUR (N)	ANTIHEMOPHILIC FACTOR (RECOMB PORC) PREVIN	COINSURANCE
PROFILNINE SD (N)	FACTOR IX, COMPLEX, PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
RECOMBINATE (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [RECOMBINANT]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
REFACTO (N)	FACTOR VIII (ANTIHEMOPHILIC FACTOR [RECOMBINANT]) PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
THROMBATE III (N)	ANTITHROMBIN III (HUMAN), PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
TRETTEN (N)	COAGULATION FACTOR XIII A-SUBUNIT	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
WILLATE (N)	ANTIHEMOPHILIC FACTOR/VWF (HUMAN)	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE
XYNTHA KIT (N)	INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PER IU	PRIOR AUTHORIZATION REQUIRED-MAY REQUIRE A COINSURANCE