Pharmacy Policy Bulletin: J-0755 Market Watch Programs – New York, Pennsylvania and West Virginia	
Number: J-0755	**Category:** Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	**Benefit(s):** Market Watch Program • **Rx with OTC Equivalent** • **New to Market** • **High Cost Low Value**
Region(s): ☐ All ☐ Delaware ☒ New York ☒ Pennsylvania ☒ West Virginia	**Additional Restriction(s):** None
Version: J-0755-041	**Original Date:** 07/01/2018
Effective Date: 07/31/2025	**Review Date:** 06/25/2025

Drugs Product(s):	• All medications not covered on the formulary due to the following Programs: Rx with OTC Equivalent, New to Market, and High Cost Low Value
FDA-Approved Indication(s):	• See individual product information

Background:	• This policy defines the criteria under which a Market Watch medication will be considered for coverage under the prescription drug benefit. This policy is to be used in conjunction with other utilization management policies for the requested medication, if applicable, based on the member's benefit. For specific categories of products, additional criteria apply as outlined in the approval criteria.
	• The High Cost Low Value Program targets selected high cost products with limited clinical value from coverage. Targeted medications will typically have equally efficacious and more cost-effective therapeutic alternatives.
	• The New to Market Program targets new products which will not be covered upon initial market launch which will allow for time to review the clinical efficacy, safety and value of the new product.
	• The FDA occasionally approves existing prescription drugs to be available without a prescription, also known as “Over-the-Counter” or ‘OTC’. Common categories of medications that can be safely used without a doctor’s prescription include certain allergy medications and most medications to treat or prevent heart burn. When the OTC version provides cost savings, the prescription version will no longer be covered under the prescription benefit, however the member will be able to purchase the medication over-the-counter.
	• Definitions:
	  ○ 'Tried and failed' will include the following situations:
	  ▪ The use of alternative drug(s) at recommended doses for an adequate duration
	  ▪ There is a documented drug interaction with the alternative drug(s)
	  ▪ There is a documented adverse drug experiences (i.e., side effects, adverse drug reaction) with the alternative drug(s) or the

	prescriber attests that the individual would have adverse drug reactions with the alternative drug(s) ○ For the purposes New York Legislature Bill A2834D, therapeutic alternatives are considered plan-preferred alternatives.

Approval Criteria

Approval Criteria

I. Contraceptives

When a benefit, coverage of an excluded contraceptive may be approved if a member meets one (1) of the following criteria **(A. or B.)**:

A. The prescribing physician indicates that the excluded drug is medically necessary.

B. The member has tried and failed one (1) therapeutic alternative **(1., 2., or 3.):**

1. For an Rx with OTC Equivalent medication, the alternative must be the similar chemical entity product which is available over the counter.

2. For a High Cost Low Value medication, the alternative must be from the middle column of the table below for the corresponding targeted medication.

3. For a New to Market medication, the alternative must be in the same therapeutic class/category as the requested medication; if none exists in the class/category, the alternative may be in a different therapeutic class/category, however it must have the same indication.

II. All Other Targeted Medications

When a benefit, coverage of a targeted medication will be approved if a member meets all of the following criteria **(A. and B.):**

A. The medication must be used for an FDA approved indication.

B. The member meets one (1) of the following **(1., 2., or 3.)**:

1. For an Rx with OTC Equivalent medication, the member must try and fail the similar chemical entity product which is available over the counter.

2. For a High Cost Low Value medication, the member must try and fail ALL therapeutic alternative(s) listed in the middle column of **Table 1**. below for the corresponding targeted medication.

3. For a New to Market medication, the member must try and fail ALL therapeutic alternatives available.

Table 1. High Cost Low Value Medications

Targeted Medication	Therapeutic Alternative(s) Note: This is ordered alphabetically by name	Associated Policies
• **DENAVIR** • **PENCICLOVIR**	• ACYCLOVIR • FAMCICLOVIR • VALACYCLOVIR	J-0396; J-0368
• **SITAVIG**	• ACYCLOVIR • FAMCICLOVIR • VALACYCLOVIR	J-0396; J-0368; J-0753
• **ALLOPURINOL 200 MG**	• ALLOPURINOL 100 MG • ALLOPURINOL 300 MG	J-0310
• **KATERZIA** • **NORLIQVA**	• AMLODIPINE TABLET	J-0942
• **CONJUPRI** • **LEVAMLODIPINE**	• AMLODIPINE • FELODIPINE	J-1039; J-0753

Targeted Medication	Therapeutic Alternative(s) Note: This is ordered alphabetically by name	Associated Policies
	• NIFEDIPINE ER	
• **ATROPINE SULFATE 1% PRESERVATIVE FREE DROPERETTE**	• **ATROPINE SULFATE 1% DROPS**	N/A
• **CONSENSI**	• AMLODIPINE + CELECOXIB • NIFEDIPINE + MELOXICAM	J-0932
• **RELEXXII** • **METHYLPHENIDATE HCL ER (GENERIC RELEXXII)**	• AMPHETAMINE/DEXTROAMPHETAMINE ER • DEXMETHYLPHENIDATE HCL ER • DEXTROAMPHETAMINE ER • METHYLPHENIDATE HCL ER	J-1426
• **ASPIRIN-OMEPRAZOLE** • **YOSPRALA**	• ASPIRIN + OMEPRAZOLE • ASPIRIN + PANTOPRAZOLE	J-0640; J-0753
• **EZALLOR**	• ATORVASTATIN • ROSUVASTATIN • SIMVASTATIN	J-0753
• **EZETIMIBE-ATORVASTATIN CALCIUM** • **ROSZET** • **ROSUVASTATIN-EZETIMIBE**	• ATORVASTATIN + EZETIMIBE • ROSUVASTATIN + EZETIMIBE	J-0303; J-0367; J-0874
• **BACLOFEN 15 mg** • **FLEQSUVY** • **LYVISPAH** • **OZOBAX**	• BACLOFEN 5 MG, 10 MG, or 20 MG • TIZANIDINE	J-0230; J-0753
• **AMRIX** • **CYCLOBENZAPRINE ER**	• BACLOFEN • CYCLOBENZAPRINE HCL • METHOCARBAMOL 500 MG OR 750 MG	J-0288
• **FEXMID**	• BACLOFEN • CYCLOBENZAPRINE HCL • METHOCARBAMOL 500 MG OR 750 MG	J-0288
• **METHOCARBAMOL 1000 MG** • **TANLOR**	• CYCLOBENZAPRINE HCl • CHLORZOXAZONE 500 MG • METHOCARBAMOL 500 MG OR 750 MG	J-0288
• **SOAANZ**	• BUMETANIDE TABLET • FUROSEMIDE TABLET • TORSEMIDE TABLET	J-1202
• **ELYXYB**	• CELECOXIB • IBUPROFEN • NAPROXEN	J-0714; J-0790
• **SEGLENTIS**	• CELECOXIB • TRAMADOL HYDROCHLORIDE 50 mg	J-0672; J-0832; J-0257
• **HEMICLOR** • **THALITONE**	• CHLORTHALIDONE • HYDROCHLOROTHIAZIDE • INDAPAMIDE	N/A
• **CHLORZOXAZONE 375 mg & 750 mg** • **LORZONE**	• CHLORZOXAZONE 500 mg • CYCLOBENZAPRINE HCL • METHOCARBAMOL 500 MG OR 750 MG	J-0361
• **PARAFON FORTE DSC**	• CHLORZOXAZONE 500 mg	N/A

Targeted Medication	Therapeutic Alternative(s) Note: This is ordered alphabetically by name	Associated Policies
	• CYCLOBENZAPRINE HCL • METHOCARBAMOL 500 MG OR 750 MG	
• **NORGESIC FORTE** • **ORPHENGESIC FORTE** • **ORPHENADRINE/ASPIRIN/CAFFEINE**	• CHLORZOXAZONE 500 mg • CYCLOBENZAPRINE • METHOCARBAMOL500 MG OR 750 MG • ORPHENADRINE + ASPIRIN + CAFFEINE	J-0948
• **JUBLIA**	• CICLOPIROX • TERBINAFINE	J-0356
• **KERYDIN** • **TAVABOROLE**	• CICLOPIROX • TERBINAFINE	J-0356; J-0749
• **CITALOPRAM 30 MG CAPSULES**	• CITALOPRAM TABLET • ESCITALOPRAM • SERTRALINE (generic)	J-1164
• **SERTRALINE 150 MG & 200 MG CAPSULES**	• CITALOPRAM • FLUOXETINE • SERTRALINE TABLET (generic)	J-1164
• **IMPEKLO**	• CLOBETASOL PROPIONATE 0.05% CREAM • CLOBETASOL PROPIONATE 0.05% GEL • CLOBETASOL PROPIONATE 0.05% LOTION • FLUOCINONIDE 0.05% CREAM	J-0872; J-0950; J-0753
• **LOREEV XR**	• CLONAZEPAM • DIAZEPAM • LORAZEPAM	N/A
• **CLONIDINE HCL ER** • **NEXICLON XR**	• CLONIDINE HCL IMMEDIATE-RELEASE TABLET	J-1217
• **HEMADY**	• DEXAMETHASONE	J-1006; J-0753
• **DICLOFENAC POTASSIUM 25 MG TABLET** • **LOFENA**	• DICLOFENAC (generics) • IBUPROFEN • MELOXICAM	J-0495
• **PENNSAID** • **DICLOFENAC SODIUM**	• DICLOFENAC • IBUPROFEN • MELOXICAM	J-0495; J-0753
• **ZIPSOR**	• DICLOFENAC • IBUPROFEN • MELOXICAM	J-0495; J-0753
• **ZORVOLEX**	• DICLOFENAC • IBUPROFEN • MELOXICAM	J-0495; J-0753
• **ZUNVEYL**	• DONEPEZIL • GALANTAMINE • RIVASTIGMINE	J-1215
• **AUVI-Q**	• EPINEPHRINE	J-0529; J-0753
• **ERMEZA** • **THYQUIDITY**	• EUTHYROX • LEVOTHYROXINE TABLET • UNITHROID	J-0928; J-0753

Targeted Medication	Therapeutic Alternative(s) Note: This is ordered alphabetically by name	Associated Policies
• **VANOS**	• FLUOCINONIDE • MOMETASONE FUROATE • TRIAMCINOLONE ACETONIDE	J-0872; J-0950
• **DICLOFENAC SODIUM 3%** • **SOLARAZE**	• FLUOROURACIL	J-0545
• **GABARONE**	• GABAPENTIN IR	J-1449
• **DARTISLA ODT**	• GLYCOPYRROLATE 2 MG TABLETS	J-1187; J-0753; J-0752
• **FULVICIN P/G 165 MG** • **GRISEOFULVIN ULTRAMICROSIZE 165 MG**	• GRISEOFULVIN MICROSIZE 500 MG TABLETS • GRISEOFULVIN ULTRAMICROSIZE 125 MG TABLETS • GRISEOFULVIN ULTRAMICROSIZE 250 MG TABLETS	J-1446
• **ALKINDI SPRINKLE** • **KHINDIVI**	• HYDROCORTISONE TABLETS	J-1047; J-0753
• **SOVUNA 200 MG** • **SOVUNA 300 MG**	• HYDROXYCHLOROQUINE 100 mg • HYDROXYCHLOROQUINE 200 MG • HYDROXYCHLOROQUINE 300 MG • HYDROXYCHLOROQUINE 400 MG	N/A
• **COXANTO** • **OXAPROZIN CAPSULES**	• IBUPROFEN • MELOXICAM • OXAPROZIN TABLETS	J-0759
• **DOLOBID (brand)**	• IBUPROFEN • MELOXICAM • NAPROXEN	J-0759
• **MELOXICAM SUSPENSION**	• IBUPROFEN SUSPENSION	J-0759
• **FENOPRON**	• IBUPROFEN • MELOXICAM • NAPROXEN	J-0759
• **INDOMETHACIN** • **TIVORBEX**	• IBUPROFEN • INDOMETHACIN • MELOXICAM • NAPROXEN	J-0759; J-0753
• **RELAFEN DS**	• IBUPROFEN • MELOXICAM • NABUMETONE	J-0759; J-0753
• **MELOXICAM CAPSULES** • **VIVLODEX**	• IBUPROFEN • MELOXICAM TABLETS • NAPROXEN	J-0355; J-0753
• **TOLECTIN**	• IBUPROFEN • MELOXICAM TABLETS • NAPROXEN	J-0759
• **DUEXIS** • **IBUPROFEN-FAMOTIDINE**	• IBUPROFEN + FAMOTIDINE • MELOXICAM + FAMOTIDINE	J-0340; J-0746
• **TOLSURA**	• ITRACONAZOLE	J-0860; J-0753
• **LULICONAZOLE** • **LUZU**	• KETOCONAZOLE • NYSTATIN	J-0801; J-0753

Targeted Medication	Therapeutic Alternative(s) Note: This is ordered alphabetically by name	Associated Policies
	• TERBINAFINE	
• **ELEPSIA XR**	• LEVETIRACETAM ER • ROWEEPRA XR	J-1079
• **NAPROXEN-ESOMEPRAZOLE** • **VIMOVO**	• MELOXICAM + PANTOPRAZOLE • NAPROXEN + OMEPRAZOLE	J-0339; J-0748
• **FORTAMET** • **METFORMIN HCL ER (GENERIC FORTAMET)**	• METFORMIN HCL ER (GENERIC OF GLUCOPHAGE XR)	J-0600
• **GLIMEPIRIDE 3 MG**	• GLIMEPIRIDE 1 MG • GLIMEPIRIDE 2 MG • GLIMEPIRIDE 4 MG	N/A
• **GLUCOPHAGE XR**	• METFORMIN HCL ER (GENERIC OF GLUCOPHAGE XR)	J-0600; J-0753
• **GLUMETZA** • **METFORMIN HCL ER (GENERIC GLUMETZA)**	• METFORMIN HCL ER (GENERIC OF GLUCOPHAGE XR)	J-0600; J-0753
• **RIOMET ER**	• METFORMIN HCL ER (GENERIC OF GLUCOPHAGE XR)	J-0600
• **METFORMIN HCL 625 MG TABLET** • **METFORMIN HCL 750 MG TABLET**	• METFORMIN HCL IR (GENERIC GLUCOPHAGE)	J-0600
• **METRONIDAZOLE 125 MG**	• METRONIDAZOLE 250 MG	J-1342
• **EPSOLAY**	• METRONIDAZOLE TOPICAL • AZELAIC ACID	J-0601
• **ONDANSETRON ORALLY DISINTEGRATING TABLET (ODT) 16 MG**	• ONDANSETRON HCL 8 MG TABLET • ONDANSETRON ODT 8 MG TABLET • ONDANSETRON 4 MG/5 ML SOLUTION	J-1181
• **OXYBUTYNIN 2.5 MG TABLET**	• OXYBUTYNIN 5 MG TABLET	N/A
• **POKONZA**	• POTASSIUM CHLORIDE CAPSULE • POTASSIUM CHLORIDE TABLET	J-XXXX
• **CLOBETASOL PROPIONATE OPHTHALMIC SUSPENSION**	• PREDNISOLONE SODIUM PHOSPHATE 1% • PREDNISOLONE ACETATE 1% • FLOUROMETHOLONE SUSPENSION 0.1%	N/A
• **RAYOS**	• PREDNISONE	J-0342
• **SYMBRAVO**	• RIZTRIPTAN + MELOXICAM • SUMATRIPTAN + MELOXICAM • ZOLMITRIPTAN + MELOXICAM	J-0714
• **TETRACYCLINE TABLET**	• TETRACYCLINE CAPSULE	J-1060
• **QDOLO** • **TRAMADOL ORAL SOLUTION** • **TRAMADOL 25 MG TABLETS** • **TRAMADOL 75 MG TABLETS**	• TRAMADOL HCL 50 MG TABLETS	J-0257; J-0832; J-0672; J-1109; J-0753
• **AKLIEF**	• TRETINOIN	J-0871
• **VENLAFAXINE BESYLATE**	• VENLAFAXINE HCL ER CAPSULE	J-0336
• **ZOLPIDEM CAPSULES**	• ZOLPIDEM TABLETS	J-0607
• **METAXALONE 640 MG**	• BACLOFEN • CYCLOBENZAPRINE HCL	J-0288

Targeted Medication	Therapeutic Alternative(s) Note: This is ordered alphabetically by name	Associated Policies
	• METHOCARBAMOL 500 MG OR 750 MG	
• **BUCAPSOL CAPSULES**	• BUSPIRONE TABLETS	J_XXXX

III. An exception to some or all of the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations

Limitations of Coverage

I. Coverage of drugs addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support effectiveness and safety in other conditions unless otherwise noted in the approval criteria.
II. This policy is to be used in conjunction with other utilization management policies for the requested medication, if applicable, based on the member's benefit.

Authorization Duration

- Commercial and HCR Plans: If approved, up to a 12 month authorization may be granted.

References:

1. DRUGDEX System (Micromedex 2.0). Greenwood Village, CO: Truven Health Analytics; 2023.