Reference number(s)
5913-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control – Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☐
Advanced Control Specialty – Choice (ACSCF)	☐
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☐

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Injectable Methotrexate

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), and Standard Control Choice Formulary (SCCF).

Plan Design Summary

This program applies to the injectable methotrexate products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Injectable Methotrexate Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	• methotrexate injection (generic) • Rasuvo (methotrexate, subcutaneous injection)
Target	• RediTrex (methotrexate, subcutaneous injection)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for the targeted product is provided when either of the following criteria is met:

- The member has had a documented intolerable adverse event to both of the preferred products, generic methotrexate injection and Rasuvo, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.
- The member meets both of the following criteria:
    - The member has had a documented intolerable adverse event to the preferred product, Rasuvo, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.
    - The member is unable to prepare and administer methotrexate injection due to dexterity issues.

References

1. Methotrexate injection [package insert]. Lake Forest, IL: Hospira, Inc.; October 2011.
2. Rasuvo [package insert]. Chicago, IL: Medexus Pharma Inc.; March 2020.
3. RediTrex [package insert]. Nashville, TN: Cumberland Pharmaceuticals, Inc.; October 2022.