

This document applies to the following:

Formulary	Applies
Standard Control (SF)	<input checked="" type="checkbox"/>
Standard Control – Choice (SCCF)	<input checked="" type="checkbox"/>
Preferred Drug Plan Design (PDPD)	<input type="checkbox"/>
Advanced Control Specialty (ACSF)	<input checked="" type="checkbox"/>
Advanced Control Specialty – Choice (ACSCF)	<input checked="" type="checkbox"/>
Managed Medicaid Template (MMT)	<input type="checkbox"/>
Marketplace (MF)	<input type="checkbox"/>
Aetna Small Group Affordable Care Act (SG ACA)	<input type="checkbox"/>
Aetna Health Exchange (AHE)	<input type="checkbox"/>
Aetna Individual Lives (IVL)	<input type="checkbox"/>
Value (VF)	<input checked="" type="checkbox"/>

Formulary	Applies
New to Market (NTM)	<input type="checkbox"/>
Standard Formulary Chart (SFC)	<input type="checkbox"/>
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	<input type="checkbox"/>
Advanced Control Specialty Formulary Chart (ACSFC)	<input type="checkbox"/>
Value Formulary Chart (VFC)	<input checked="" type="checkbox"/>
Medical Benefit	<input type="checkbox"/>
Medical Benefit: Advanced Biosimilars First	<input type="checkbox"/>
Medical Benefit: Managed Medicaid (MMMB)	<input type="checkbox"/>
Medicare Part B	<input type="checkbox"/>
Medicare Part B: Advanced Biosimilars First	<input type="checkbox"/>

Exceptions Criteria

Epidermal Growth Factor Receptor (EGFR) Inhibitors

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), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty – Choice Formulary (ACSCF), Value Formulary (VF), and Value Formulary Chart (VFC).

Plan Design Summary

This program applies to the EGFR products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product 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. EGFR Inhibitors

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

	Product(s)
Preferred	<ul style="list-style-type: none"> erlotinib (generic) gefitinib (generic) Tagrisso (osimertinib)
Target	<ul style="list-style-type: none"> Iressa (gefitinib)

Exception Criteria

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

Coverage for a targeted product is provided when both of the following criteria are met:

- Member has a documented intolerable adverse event to gefitinib and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.
- Member has a documented inadequate response or intolerable adverse event with erlotinib and Tagrisso.

References

1. Erlotinib [package insert]. Pennington, NJ: Zydus Pharmaceuticals USA, Inc.; October 2023.
2. Gefitinib [package insert]. Orlando, FL: Ingenus Pharmaceuticals, LLC; April 2023.
3. Iressa [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2023.
4. Tagrisso [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; September 2024.