



# Policy: Non-Preferred Drug Coverage Review - (Formulary Exception Criteria)

**REVIEW DATE:** 07/07/2025

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## **INSTRUCTIONS FOR USE**

*The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.*

## **Cigna National Formulary Coverage Policy**

The Cigna National Formulary prescription drug list does not cover certain products unless those products are approved based upon a medical necessity review.

**Cigna covers these products as medically necessary when the Product Specific Exception Criteria are met.** Refer to the [Non-Preferred Drug Coverage Review - \(Formulary Exception Criteria\) List](#) document for an up-to-date list of non-covered products (alphabetical by *Brand Name* column) and their exception criteria.

**Any other exception is considered not medically necessary.**

Approval duration is 12 months unless otherwise noted.

**Documentation:** When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

Criteria will be updated as new published data are available.

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