2021 STEP THERAPY CRITERIA

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Step Therapy Group – **Febuxostat ST**

Drug Name(s):
febuxostat
ULORIC

Criteria:
This program applies to new starts only.
Criteria for approval require the following:
1. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. Patient's medication history includes evidence of a claim within the past 90 days for generic allopurinol OR
    d. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to generic allopurinol

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Fluticasone-Salmeterol ST**

Drug Name(s):
fluticasone propionate/salmeterol inhaler
wixela inhaler

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of Advair Diskus within the past 90 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to Advair Diskus

Step Therapy Group – **GLP-1 Agonists ST**

Drug Name(s):
ADLYXIN
ADLYXIN STARTER PACK
BYDUREON BCISE
BYDUREON PEN
BYETTA
OZEMPIC
RYBELSUS
TRULICITY
VICTOZA

Criteria:
This program applies to new starts only.
Criteria for approval require the following:
1. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    b. Prescriber states the patient is currently using the requested agent OR
    c. Patient's medication history includes use of metformin or an agent containing metformin within the past 90 days OR
    d. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to metformin or an agent containing metformin.

For Ozempic, Trulicity, and Victoza: NO prerequisites are required for diagnoses of type 2 diabetes mellitus and multiple cardiovascular risk factors or established cardiovascular disease.

Medications subject to step therapy will be covered when the above criteria are met.

Approval authorizations will apply to the requested medication only.

Step Therapy Group – **Insulin ST - Combinations**

Drug Name(s):

INSULIN ASPART PROTAMINE/INSULIN ASPART 70/30
INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN
INSULIN LISPRO PROTAMINE/INSULIN LISPRO KWIKPEN
NOVOLIN 70/30
NOVOLIN 70/30 FLEXPEN
NOVOLIN 70/30 RELION
NOVOLOG MIX 70/30
NOVOLOG MIX 70/30 PREFILLED FLEXPEN

Criteria:

This program applies to new starts only.
Criteria for approval require the following:
1. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    b. Prescriber states the patient is currently using the requested agent OR
    c. Patient's medication history includes use of preferred Mix insulin (Humalog Mix or Humulin 70/30) within the past 90 days OR
    d. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to preferred Mix insulin (Humalog Mix or Humulin 70/30)

Medication subject to step therapy will be covered when the above criteria are met.

Approval authorizations will apply to the requested medication only.

Step Therapy Group – **Insulin ST - Intermediate Acting**

Drug Name(s):
NOVOLIN N
NOVOLIN N FLEXPEN RELION
NOVOLIN N RELION

Criteria:
This program applies to new starts only.
Criteria for approval require the following:
1. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    b. Prescriber states the patient is currently using the requested agent OR
    c. Patient's medication history includes use of preferred NPH insulin (Humulin N) within the past 90 days OR
    d. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to preferred NPH insulin (Humulin N)

Medication subject to step therapy will be covered when the above criteria are met.

Approval authorizations will apply to the requested medication only.

Step Therapy Group – **Insulin ST - Rapid Acting**

Drug Name(s):
ADMELOG
ADMELOG SOLOSTAR
APIDRA
APIDRA SOLOSTAR
FIASP
FIASP FLEXTOUCH
FIASP PENFILL
INSULIN ASPART
INSULIN ASPART FLEXPEN
INSULIN ASPART PENFILL
INSULIN LISPRO
INSULIN LISPRO JUNIOR KWIKPEN
INSULIN LISPRO KWIKPEN
LYUMJEV
LYUMJEV KWIKPEN
NOVOLOG
NOVOLOG FLEXPEN
NOVOLOG PENFILL

Criteria:
This program applies to new starts only.
Criteria for approval require the following:
1. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    b. Prescriber states the patient is currently using the requested agent OR
    c. Patient's medication history includes use of preferred rapid insulin (Humalog) within the past 90 days OR
    d. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to preferred rapid insulin (Humalog)

Medication subject to step therapy will be covered when the above criteria are met.

Approval authorizations will apply to the requested medication only.

Step Therapy Group – **Insulin ST - Short Acting**

Drug Name(s):
NOVOLIN R
NOVOLIN R FLEXPEN RELION
NOVOLIN R RELION

Criteria:
This program applies to new starts only.
Criteria for approval require the following:
1. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    b. Prescriber states the patient is currently using the requested agent OR
    c. Patient's medication history includes use of preferred regular insulin (Humulin R) within the past 90 days OR
    d. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to preferred regular insulin (Humulin R)

Medication subject to step therapy will be covered when the above criteria are met.

Approval authorizations will apply to the requested medication only.

Step Therapy Group – **PPI ST - Aciphex**

Drug Name(s):
ACIPHEX tablet

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **PPI ST - Nexium**

Drug Name(s):
NEXIUM 10 mg, 20 mg, 40 mg granules for suspension
NEXIUM capsule

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **PPI ST - Prevacid**

Drug Name(s):
PREVACID
PREVACID SOLUTAB

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **PPI ST - Protonix**

Drug Name(s):
PROTONIX tablet

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **PPI ST - Zegerid**

Drug Name(s):
ZEGERID

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Rho Kinase Inhibitor ST - Rhopressa**

Drug Name(s):
RHOPRESSA

Criteria:
This program applies to new starts only.
Criteria for approval require ONE of the following:
1. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
2. Prescriber states the patient is currently using the requested agent OR
3. Patient's medication history includes previous use of a generic ophthalmic prostaglandin agent in the past 90 days OR
4. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to a generic ophthalmic prostaglandin agent

Medications subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Rho Kinase Inhibitor ST - Rocklatan**

Drug Name(s):
ROCKLATAN

Criteria:
This program applies to new starts only.
Criteria for approval require ONE of the following:
1. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
2. Prescriber states the patient is currently using the requested agent OR
3. Patient's medication history includes previous use of a generic ophthalmic prostaglandin agent in the past 90 days OR
4. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to a generic ophthalmic prostaglandin agent

Medications subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Statins ST - Crestor**

Drug Name(s):
CRESTOR

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Statins ST - Lescol XL**

Drug Name(s):
LESCOL XL

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Statins ST - Lipitor**

Drug Name(s):
LIPITOR

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Statins ST - Vytorin**

Drug Name(s):
VYTORIN

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Statins ST - Zocor**

Drug Name(s):
ZOCOR

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Amerge**

Drug Name(s):
AMERGE

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Frova**

Drug Name(s):
FROVA

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Imitrex injectable**

Drug Name(s):
IMITREX
IMITREX STATDOSE REFILL
IMITREX STATDOSE SYSTEM

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Imitrex nasal spray**

Drug Name(s):
IMITREX

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Imitrex tablet**

Drug Name(s):
IMITREX

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Maxalt**

Drug Name(s):
MAXALT
MAXALT-MLT

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Relpax**

Drug Name(s):
RELPAX

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Treximet**

Drug Name(s):
TREXIMET 85-500 mg tablet

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Triptans ST - Zomig**

Drug Name(s):
ZOMIG
ZOMIG ZMT

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Urinary Incontinence ST - Detrol/Detrol LA**

Drug Name(s):
DETROL
DETROL LA

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Urinary Incontinence ST - Ditropan XL**

Drug Name(s):
DITROPAN XL 5mg, 10 mg tablet

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group – **Urinary Incontinence ST - Vesicare**

Drug Name(s):
VESICARE

Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes evidence of a claim for the generic equivalent agent within the past 999 days OR
2. Patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.