

2021 STEP THERAPY CRITERIA

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No changes made since 03/2021	COMPLETE 2021
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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.