2021 STEP THERAPY CRITERIA

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

Drug Name(s):
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 – **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.