

## 2022 STEP THERAPY CRITERIA

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**Step Therapy Group:**

Febuxostat ST

**Drug Name(s)**

Febuxostat

Uloric

**Criteria:**

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 within the past 90 days OR
- C. Patient's medication history includes use of generic allopurinol within the past 90 days OR
- D. Patient has an intolerance or hypersensitivity to generic allopurinol OR
- E. Patient had an ineffective treatment response to generic allopurinol OR
- F. Patient has an FDA labeled contraindication 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

Fluticasone Propionate/Salmeterol Diskus

Wixela Inhub

**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 an intolerance or hypersensitivity to Advair Diskus OR
3. Patient had an ineffective treatment response to Advair Diskus OR
4. Patient has an FDA labeled contraindication to Advair Diskus

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

**Step Therapy Group:**

GLP-1 Agonists ST

**Drug Name(s)**

Adlyxin

Adlyxin Starter Pack

Bydureon Bcise

Bydureon Pen

Byetta

Ozempic

Rybelsus

Trulicity

Victoza

**Criteria:**

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 within the past 90 days OR

c. Patient's medication history includes use of metformin or an agent containing metformin within the past 90 days OR

d. Patient has an intolerance or hypersensitivity to metformin or an agent containing metformin OR

e. Patient had an ineffective treatment response to metformin or an agent containing metformin OR

f. Patient has an FDA labeled contraindication 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

Insulin Aspart Protamine/Insulin Aspart Flexpen

Insulin Lispro Protamine/Insulin Lispro Kwikpen

Novolin 70/30

Novolin 70/30 Flexpen Relion

Novolin 70/30 Relion

Novolog Mix 70/30

Novolog Mix 70/30 Prefilled Flexpen

**Criteria:**

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 within the past 90 days OR
- c. Patient's medication history includes use of a preferred Mix insulin (Humalog Mix or Humulin 70/30) within the past 90 days OR
- d. Patient has an intolerance or hypersensitivity to a preferred Mix insulin (Humalog Mix or Humulin 70/30) OR
- e. Patient had an ineffective treatment response to a preferred Mix insulin (Humalog Mix or Humulin 70/30) OR
- f. Patient has an FDA labeled contraindication to a 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:**

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 within the past 90 days OR
- c. Patient's medication history includes use of a preferred NPH insulin (Humulin N) within the past 90 days OR
- d. Patient has an intolerance or hypersensitivity to a preferred NPH insulin (Humulin N) OR
- e. Patient had an ineffective treatment response to a preferred NPH insulin (Humulin N) OR
- f. Patient has an FDA labeled contraindication to a 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

Novolog

Novolog Flexpen

Novolog Penfill

**Criteria:**

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 within the past 90 days OR
- c. Patient's medication history includes use of a preferred rapid insulin (Humalog or Lyumjev) within the past 90 days OR
- d. Patient has an intolerance or hypersensitivity to a preferred rapid insulin (Humalog or Lyumjev) OR
- e. Patient had an ineffective treatment response to a preferred rapid insulin (Humalog or Lyumjev) OR
- f. Patient has an FDA labeled contraindication to a preferred rapid insulin (Humalog or Lyumjev)

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

Novolin R Relion

**Criteria:**

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 within the past 90 days OR
- c. Patient's medication history includes use of a preferred regular insulin (Humulin R) within the past 90 days OR
- d. Patient has an intolerance or hypersensitivity to a preferred regular insulin (Humulin R) OR
- e. Patient had an ineffective treatment response to a preferred regular insulin (Humulin R) OR
- f. Patient has an FDA labeled contraindication to a 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

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 XI

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 Injectable

Imitrex Statdose Refill

Imitrex Statdose System

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 Nasal Spray

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 Tablet

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 Mlt

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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

**Criteria:**

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication 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 use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

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