

2023 STEP THERAPY CRITERIA

TABLE OF CONTENTS

Aciphex	10
Adlyxin	5
Adlyxin Starter Pack.....	5
Admelog.....	8
Admelog Solostar	8
Apidra	8
Apidra Solostar.....	8
Bydureon Bcise.....	5
Bydureon Pen.....	5
Byetta	5
Crestor	15
Detrol.....	28
Detrol LA	29
Ditropan XL	30
Febuxostat	3
Fiasp.....	8
Fiasp Flextouch.....	8
Fiasp Penfill	8
Fluticasone Propionate/Salmeterol.....	4
Fluticasone Propionate/Salmeterol Diskus.....	4
Frova	20
Imitrex Injectable	21
Imitrex Nasal Spray.....	22
Imitrex Statdose System	21
Imitrex Tablet.....	23
Insulin Aspart	8
Insulin Aspart Flexpen	8
Insulin Aspart Penfill.....	8
Insulin Aspart Protamine/Insulin Aspart	6
Insulin Aspart Protamine/Insulin Aspart Flexpen.....	6
Insulin Lispro	8
Insulin Lispro Junior Kwikpen.....	8
Insulin Lispro Kwikpen	8
Insulin Lispro Protamine/Insulin Lispro Kwikpen	6
Lescol XL.....	16
Lipitor.....	17
Maxalt.....	24
Maxalt-MLT.....	24
Mounjaro	5
Nexium.....	11
Novolin 70/30.....	6
Novolin 70/30 Flexpen Relion	6

Novolin 70/30 Relion.....	6
Novolin N.....	7
Novolin N Flexpen.....	7
Novolin N Flexpen Relion.....	7
Novolin N Relion.....	7
Novolin R.....	9
Novolin R Flexpen.....	9
Novolin R Flexpen Relion.....	9
Novolin R Relion.....	9
Novolog.....	8
Novolog Flexpen.....	8
Novolog Flexpen Relion.....	8
Novolog Mix 70/30.....	6
Novolog Mix 70/30 Prefilled Flexpen.....	6
Novolog Penfill.....	8
Novolog Relion.....	8
Ozempic.....	5
Prevacid.....	12
Prevacid Solutab.....	12
Protonix.....	13
Relpax.....	25
Rybelsus.....	5
Treximet.....	26
Trulicity.....	5
Uloric.....	3
Vesicare.....	31
Victoza.....	5
Vytorin.....	18
Wixela Inhub.....	4
Zegerid.....	14
Zocor.....	19
Zomig.....	27
Zomig ZMT.....	27

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

Mounjaro

Ozempic

Rybelsus

Trulicity

Victoza

Criteria:

Criteria for approval require BOTH of the following:

1. Patient has an FDA labeled indication for the requested agent AND
2. 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 diagnosis 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

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 Flexpen Relion

Novolog Penfill

Novolog 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 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 Flexpen Relion

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 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:

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 – 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 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 ZMT

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

Drug Name(s)

Detrol

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 LA

Drug Name(s)

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.