Actinic Keratosis Agents
Step Therapy Guidelines

Affected Medication(s)
- Diclofenac sodium topical gel
- Solaraze (diclofenac sodium) topical gel
- Zyclara (imiquimod) topical cream pack
- Zyclara (imiquimod) topical cream metered dose pump

Step Therapy Requirements

Step 1 Drug(s):
- Imiquimod topical cream pack

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Amphetamine oral suspension
Step Therapy Guidelines

Affected Medication(s)
- Adzenys ER oral suspension
- Dyanavel XR oral suspension

Step Therapy Requirements

Step 1 Drug(s):
- Dextroamphetamine sulfate oral solution
- Methylphenidate HCl oral solution

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:
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### Affected Medication(s)

- Amrix (cyclobenzaprine HCl) ER oral capsule
- Cyclobenzaprine ER oral capsule

### Step Therapy Requirements

**Step 1 Drug(s):**
- Cyclobenzaprine HCl oral tablet

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Anticoagulant Agents
#### Step Therapy Guidelines

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Bevyxxa (betrixaban maleate) oral capsule</td>
</tr>
<tr>
<td>- Pradaxa (dabigatran etexilate mesylate) oral capsule</td>
</tr>
<tr>
<td>- Savaysa (edoxaban tosylate) oral tablet</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1 Drug(s):</strong></td>
</tr>
<tr>
<td>- Eliquis (apixaban) oral tablet</td>
</tr>
<tr>
<td>- Xarelto (rivaroxaban) oral tablet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prescription claim for <strong>TWO</strong> Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)</td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
</tr>
<tr>
<td>b. If no, continue to #2</td>
</tr>
<tr>
<td>2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to <strong>TWO</strong> Step 1 Drug is required</td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
</tr>
<tr>
<td>b. If no, clinical review required</td>
</tr>
</tbody>
</table>

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Antidepressant Agents
## Step Therapy Guidelines

### Affected Medication(s)
- Desvenlafaxine ER oral tablet
- Desvenlafaxine fumarate ER oral tablet
- Fetzima (levomilnacipran HCl) SA oral capsule
- Forfivil XL (bupropion HCl) ER oral tablet
- Irenka (duloxetine HCl) DR oral capsule
- Khedezla (desvenlafaxine) ER oral tablet
- Marplan (isocarboxazid) oral tablet
- Pexeva (paroxetine mesylate) oral tablet
- Surmontil (trimipramine maleate) oral capsule
- Trimipramine maleate oral capsule
- Trintellix (vortioxetine hydrobromide) oral tablet
- Viibryd (vilazodone HCl) oral tablet

### Step Therapy Requirements

#### Step 1 Drug(s):
- Citalopram hydrobromide oral tablet
- Desvenlafaxine succinate ER oral tablet
- Escitalopram oxalate oral tablet
- Fluoxetine HCl oral tablet
- Fluvoxamine maleate oral tablet
- Paroxetine HCl oral tablet
- Sertraline HCl oral tablet
- Venlafaxine HCl oral tablet
- Duloxetine HCl oral capsule

#### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.

Last Reviewed: 10/3/18
Effective Date: 1/1/19
# Antiemetic Agents
## Step Therapy Guidelines

### Affected Medication(s)
- Aprepitant oral capsule
- Emend (aprepitant) oral capsule
- Emend (aprepitant) oral suspension

### Step Therapy Requirements

#### Step 1 Drug(s):
- Ondansetron HCl oral tablet
- Ondansetron ODT oral tablet

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Antiglaucoma Agents
Step Therapy Guidelines

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Azopt (brinzolamide) ophthalmic drops</td>
</tr>
<tr>
<td>• Cosopt PF (dorzolamide HCl-timolol maleate) ophthalmic droperette</td>
</tr>
<tr>
<td>• Lumigan (bimatoprost) ophthalmic drops</td>
</tr>
<tr>
<td>• Rescula (unoprostone isopropyl) ophthalmic drops</td>
</tr>
<tr>
<td>• Rhopressa (netarsudil mesylate) ophthalmic drops</td>
</tr>
<tr>
<td>• Travatan Z (travoprost) ophthalmic drops</td>
</tr>
<tr>
<td>• Vyzulta (latanoprostene bunod) ophthalmic drops</td>
</tr>
<tr>
<td>• Zioptan (tafluprost) ophthalmic droperette</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
</tr>
</thead>
</table>

**Step 1 Drug(s):**
- Brimonidine drops
- Carteolol drops
- Dorzolamide drops
- Latanoprost drops
- Levobunolol drops
- Timolol maleate drops

<table>
<thead>
<tr>
<th>Step Therapy Criteria</th>
</tr>
</thead>
</table>
1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
**Affected Medication(s)**

- Amlodipine besylate-valsartan-hydrochlorothiazide oral tablet
- Atacand (candesartan cilexetil) oral tablet
- Atacand HCT (candesartan cilexetil-hydrochlorothiazide) oral tablet
- Candesartan cilexetil oral tablet
- Candesartan cilexetil-hydrochlorothiazide oral tablet
- Captopril-hydrochlorothiazide oral tablet
- Dutoprol (metoprolol succinate-hydrochlorothiazide) oral tablet
- Edarbi (azilsartan medoxomil) oral tablet
- Edarbyclor (azilsartan medoxomil-chlorthalidone) oral tablet
- Eprosartan tablet
- Exforge HCT (amlodipine besylate-valsartan-hydrochlorothiazide) oral tablet
- Micardis HCT (telmisartan-hydrochlorothiazide) oral tablet
- Nadolol-bendroflumethiazide
- Olmesartan-amlodipine-hydrochlorothiazide oral tablet
- Prestalia (perindopril arginine-amlodipine besylate) oral tablet
- Tekturna (aliskiren hemifumarate) oral tablet
- Tekturna HCT (aliskiren hemifumarate-hydrochlorothiazide) oral tablet
- Telmisartan-amlodipine besylate oral tablet
- Telmisartan-hydrochlorothiazide oral tablet
- Tribenzor (olmesartan medoxomil-amlodipine besylate-hydrochlorothiazide) oral tablet
- Twynsta (telmisartan-amlodipine besylate) oral tablet

**Step Therapy Requirements**

**Step 1 Drug(s):**

- Bisoprolol-hydrochlorothiazide oral tablet
- Candesartan cilexetil oral tablet
- Irbesartan oral tablet
- Irbesartan-hydrochlorothiazide oral tablet
- Losartan potassium oral tablet
- Losartan-hydrochlorothiazide oral tablet
- Olmesartan medoxomil oral tablet
- Olmesartan-hydrochlorothiazide oral tablet
- Valsartan oral tablet
- Valsartan-hydrochlorothiazide oral tablet

**Step Therapy Criteria**

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Atypical Antipsychotic Agents
Step Therapy Guidelines

Affected Medication(s)

- Fanapt (iloperidone) oral tablet
- Invega (paliperidone) ER oral tablet
- Paliperidone ER oral tablet
- Rexulti (brexpiprazole) oral tablet
- Saphris (asenapine maleate) sublingual tablet

Step Therapy Requirements

Step 1 Drug(s):

- Olanzapine oral tablet
- Quetiapine fumarate oral tablet
- Risperidone oral tablet

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   
   b. If no, clinical review required

Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
## Bisphosphonate Agents
### Step Therapy Guidelines

**Affected Medication(s)**

- Actonel (risedronate sodium) oral tablet
- Atelvia (risedronate sodium) DR oral tablet
- Binosto (alendronate sodium) effervescent tablet
- Fosamax Plus D (alendronate sodium-cholecalciferol) oral tablet
- Risedronate sodium DR oral tablet
- Risedronate sodium oral tablet

**Step Therapy Requirements**

**Step 1 Drug(s):**

- Alendronate sodium oral tablet

**Step Therapy Criteria**

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required

   a. If yes, approve for 12 months
   
   b. If no, clinical review required

**Note:**

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
## Clindacin® (clindamycin phosphate)
### Step Therapy Guidelines

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
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</thead>
<tbody>
<tr>
<td>• Clindacin ETZ (clindamycin phosphate) topical swab</td>
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</tr>
<tr>
<td>• Clindacin P (clindamycin phosphate) topical swab</td>
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<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1 Drug(s):</strong></td>
<td></td>
</tr>
<tr>
<td>• Clindamycin phosphate topical gel</td>
<td></td>
</tr>
<tr>
<td>• Clindamycin phosphate topical solution</td>
<td></td>
</tr>
<tr>
<td>• Clindamycin phosphate topical lotion</td>
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<table>
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<th>Step Therapy Criteria</th>
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<tbody>
<tr>
<td>1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)</td>
<td></td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
<td></td>
</tr>
<tr>
<td>b. If no, continue to #2</td>
<td></td>
</tr>
<tr>
<td>2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required</td>
<td></td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
<td></td>
</tr>
<tr>
<td>b. If no, clinical review required</td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
## Affected Medication(s)

### Step 2 Drug(s)
- Linzess (linaclotide) oral capsule
- Movantik (naloxegol) oral tablet
- Symproic (naldeemedine) oral tablet

### Step 3 Drug(s)
- Amitiza (lubiprostone) oral capsule
- Motegrity (prucalopride) oral tablet
- Trulance (plecanatide) oral tablet

## Step Therapy Requirements

### Step 1 Drug(s):
- polyethylene glycol 3350 powder
- lactulose packet

### Step 2 Drug(s)
- Linzess (linaclotide) oral capsule
- Movantik (naloxegol) oral tablet
- Symproic (naldeemedine) oral tablet

## Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes for Step 2 drug, approve for 12 months.
   - b. If yes for Step 3 drug, continue to #3
   - c. If no for Step 2 or Step 3 drug continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   - a. If yes for Step 2 drug, approve for 12 months
   - b. If yes for Step 3 Drug, continue to #3
   - c. If no for Step 2 or Step 3 drug clinical review required

3. Prescription claim for TWO Step 2 Drug(s) within the past 180 days (Note: 90 days of claim history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #4

4. If no claim history of Step 2 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 2 Drugs required.
a. If yes, approve for 12 months
b. If no, clinical review required

Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Coreg CR® (carvedilol phosphate)
## Step Therapy Guidelines

### Affected Medication(s)
- Carvedilol ER (carvedilol phosphate) oral capsule
- Coreg CR (carvedilol phosphate) oral capsule

### Step Therapy Requirements

#### Step 1 Drug(s):
- Bisoprolol fumarate oral tablet
- Carvedilol oral tablet
- Metoprolol succinate ER oral tablet

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Dificid® (fidaxomicin)
Step Therapy Guidelines

<table>
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<th>Affected Medication(s)</th>
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<tbody>
<tr>
<td>• Dificid (fidaxomicin) oral tablet</td>
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<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
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<tbody>
<tr>
<td><strong>Step 1 Drug(s):</strong></td>
</tr>
<tr>
<td>• Metronidazole oral tablet</td>
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<tr>
<td>• Vancomycin HCl oral capsule</td>
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<tr>
<td>1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)</td>
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<tr>
<td>a. If yes, approve for 12 months</td>
</tr>
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<td>b. If no, continue to #2</td>
</tr>
<tr>
<td>2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required</td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
</tr>
<tr>
<td>b. If no, clinical review required</td>
</tr>
</tbody>
</table>

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Dipeptidyl Peptidase-4 Enzyme Inhibitor Agents
Step Therapy Guidelines

Affected Medication(s)

- Jentadueto (linagliptin-metformin HCl) oral tablet
- Jentadueto XR (linagliptin-metformin HCl) oral tablet
- Tradjenta (linagliptin) oral tablet
- Alogliptin benzoate oral tablet
- Alogliptin benzoate-pioglitazone HCl oral tablet
- Janumet (sitagliptin phosphate-metformin HCl) oral tablet
- Janumet XR (sitagliptin phosphate-metformin HCl) oral tablet
- Januvia (sitagliptin phosphate) oral tablet
- Kazano (alogliptin benzoate-metformin HCl) oral tablet
- Kombiglyze XR (saxagliptin HCl-metformin HCl) oral tablet
- Onglyza (saxagliptin HCl) oral tablet
- Oseni (alogliptin benzoate-pioglitazone HCl) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER oral tablet

Step 2 Drug(s):

- Jentadueto (linagliptin-metformin HCl) oral tablet
- Jentadueto XR (linagliptin-metformin HCl) oral tablet
- Tradjenta (linagliptin) oral tablet

Step 3 Drug(s):

- Alogliptin benzoate oral tablet
- Alogliptin benzoate-pioglitazone HCl oral tablet
- Janumet (sitagliptin phosphate-metformin HCl) oral tablet
- Janumet XR (sitagliptin phosphate-metformin HCl) oral tablet
- Januvia (sitagliptin phosphate) oral tablet
- Kazano (alogliptin benzoate-metformin HCl) oral tablet
- Kombiglyze XR (saxagliptin HCl-metformin HCl) oral tablet
- Onglyza (saxagliptin HCl) oral tablet
- Oseni (alogliptin benzoate-pioglitazone HCl) oral tablet

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3  
b. If no, clinical review required

3. Prescription claim for ONE Step 2 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months  
   b. If no, continue to #4

4. If no claim history of Step 2 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 2 Drug is required.
   a. If yes, approve for 12 months  
   b. If no, clinical review is required

Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
**Evzio® (naloxone HCl)**

*Step Therapy Guidelines*

### Affected Medication(s)
- Evzio (naloxone HCl) auto injector

### Step Therapy Requirements

**Step 1 Drug(s):**
- Naloxone HCl syringe
- Naloxone HCl vial
- Narcan (naloxone HCl) nasal spray

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Affected Medication(s)

- Fabior® (tazarotene) topical foam

Step Therapy Requirements

Step 1 Drug(s):

- Avita® (tretinoin) topical cream
- Avita® (tretinoin) topical gel
- Tretinoin topical cream
- Tretinoin topical gel

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Giazo® (balsalazide disodium)  
Step Therapy Guidelines

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Giazo (balsalazide disodium) oral tablet</td>
</tr>
</tbody>
</table>

**Step Therapy Requirements**

**Step 1 Drug(s):**

• Balsalazide disodium oral capsule

**Step Therapy Criteria**

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Affected Medication(s)

Step 2 Drug(s):

- Adlyxin (lixisenatide) subcutaneous pen injector
- Bydureon Pen (exenatide microspheres) subcutaneous pen injector
- Bydureon (exenatide microspheres) vial for subcutaneous injection
- Bydureon BCise (exenatide microspheres) subcutaneous auto injector
- Byetta (exenatide) subcutaneous pen injector
- Tanzeum (albiglutide) subcutaneous pen injector
- Trulicity (dulaglutide) subcutaneous pen injector
- Victoza 2-Pak (liraglutide) subcutaneous pen injector
- Victoza 3-Pak (liraglutide) subcutaneous pen injector

Step 3 Drug(s):

- Ozempic (semaglutide) subcutaneous pen injector

Step Therapy Requirements

Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER tablet

Step 2 Drug(s):

- Adlyxin (lixisenatide) subcutaneous pen injector
- Bydureon Pen (exenatide microspheres) subcutaneous pen injector
- Bydureon (exenatide microspheres) vial
- Bydureon BCise (exenatide microspheres) subcutaneous auto injector
- Byetta (exenatide) subcutaneous pen injector
- Tanzeum (albiglutide) subcutaneous pen injector
- Trulicity (dulaglutide) subcutaneous pen injector
- Victoza 2-Pak (liraglutide) subcutaneous pen injector
- Victoza 3-Pak (liraglutide) subcutaneous pen injector

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
   
   b. If no, clinical review required
3. Prescription claim for TWO Step 2 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #4

4. If no claim history of Step 2 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 2 Drugs is required.
   a. If yes, approve for 12 months
   b. If no, clinical review is required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
## Inhaled Corticosteroid- Long Acting Beta Agonist Combination Agents
### Step Therapy Guidelines

**Affected Medication(s)**
- AirDuo RespiClick (fluticasone propionate-salmeterol xinafoate) inhalation powder
- Dulera (mometasone furoate/formoterol fumarate) inhalation powder

### Step Therapy Requirements

**Step 1 Drug(s):**
- Advair HFA (fluticasone propionate-salmeterol xinafoate) inhalation aerosol
- Breo Ellipta (fluticasone furoate-vilanterol trifenate) inhalation powder
- Symbicort (budesonide/formoterol fumarate) inhalation powder

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Insomnia Agents
Step Therapy Guidelines

Affected Medication(s)

- Edluar (zolpidem tartrate) sublingual tablet
- Rozerem (ramelteon) oral tablet
- Silenor (doxepin HCl) oral tablet
- Ramelteon oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Eszopiclone oral tablet
- Zaleplon oral capsule
- Zolpidem tartrate oral tablet

Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Affected Medication(s)

- Istalol (timolol maleate) ophthalmic drops

### Step Therapy Requirements

#### Step 1 Drug(s):

- Timolol maleate ophthalmic drops

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   
   b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
**Jalyn® (dutasteride-tamsulosin HCl) Step Therapy Guidelines**

**Affected Medication(s)**
- Dutasteride-tamsulosin HCl oral capsule
- Jalyn (dutasteride-tamsulosin HCl) oral capsule

**Step Therapy Requirements**

**Step 1 Drug(s):**
- Finasteride oral tablet
- Tamsulosin HCl oral capsule

**Step Therapy Criteria**

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Affected Medication(s)

- Stiolto Respimat (tiotropium bromide-olodaterol HCl) inhalation spray

### Step Therapy Requirements

**Step 1 Drug(s):**

- Incruse Ellipta (umeclidinium bromide) inhalation powder

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

**Note:**

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Affected Medication(s)

- Aracpta Neohaler (indacaterol maleate) inhalation powder
- Brovana (arformoterol tartrate) inhalation solution
- Perforomist (formoterol fumarate) inhalation solution

### Step Therapy Requirements

**Step 1 Drug(s):**

- Serevent Diskus (salmeterol xinafoate) inhalation powder
- Striverdi Respimat (olodaterol) inhaler spray

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Affected Medication(s)

- Tudorza Pressair (aclidinium bromide) inhalation powder
- Lonhala Magnair (glycopyrrolate) nebulizer
- Yupelri (revefenacin) solution

### Step Therapy Requirements

**Step 1 Drug(s):**

- Incruse Ellipta (umeclidinium bromide) inhalation powder
- Spiriva (tiotropium bromide) Handihaler/Respimat

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Long-Acting Insulin Agents

#### Step Therapy Guidelines

**Affected Medication(s)**

- Basaglar Kwikpen U-100 (insulin glargine) subcutaneous insulin pen
- Levemir (insulin detemir) subcutaneous vial
- Levemir Flextouch (insulin detemir) subcutaneous insulin pen
- Tresiba Flextouch U-100 (insulin degludec) subcutaneous insulin pen
- Tresiba Flextouch U-200 (insulin degludec) subcutaneous insulin pen

**Step Therapy Requirements**

**Step 1 Drug(s):**

- Lantus (insulin glargine) subcutaneous vial
- Lantus Solostar (insulin glargine) subcutaneous insulin pen
- Toujeo Max Solostar (insulin glargine) subcutaneous insulin pen
- Toujeo Solostar (insulin glargine) subcutaneous insulin pen

**Step Therapy Criteria**

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required

   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Long-Acting Opioid Agents
Step Therapy Guidelines

Affected Medication(s)

- Hydromorphone ER oral tablet
- Nucynta ER oral tablet
- Oxycodone HCl ER oral tablet
- Oxycontin (oxycodone HCl) oral tablet
- Xtampza ER (oxycodone myristate) oral capsule

Step Therapy Requirements

Step 1 Drug(s):
- Fentanyl transdermal patch
- Morphine sulfate ER oral tablet
- Morphine sulfate ER oral capsule
- Oxymorphone ER oral tablet

Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Metoclopramide ODT
## Step Therapy Guidelines

### Affected Medication(s)
- Metoclopramide HCl ODT tablet
- Metozolv ODT (metoclopramide HCl) tablet

### Step Therapy Requirements

#### Step 1 Drug(s):
- Metoclopramide HCl oral tablet
- Metoclopramide HCl oral solution

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

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**Note:**

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Affected Medication(s)
- Actoplus MET XR (pioglitazone HCl-metformin HCl) oral tablet
- Cycloset (bromocriptine mesylate) oral tablet
- Duetact (pioglitazone HCl-glimepiride) oral tablet
- Pioglitazone HCl-glimepiride oral tablet

### Step Therapy Requirements
#### Step 1 Drug(s):
- Metformin HCl oral tablet
- Metformin HCl ER oral tablet

### Step Therapy Criteria
1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Namenda XR® (memantine HCl)
## Step Therapy Guidelines

### Affected Medication(s)
- Memantine HCl ER oral capsule
- Namenda XR (memantine HCl) oral capsule

### Step Therapy Requirements

#### Step 1 Drug(s):
- Memantine HCl oral tablet

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
## Namzaric® (memantine HCl-donepezil HCl) Step Therapy Guidelines

### Affected Medication(s)
- Namzaric (memantine HCl-donepezil HCl) oral capsule

### Step Therapy Requirements

**Step 1 Drug(s):**
- Memantine HCl oral tablet
- Donepezil HCl oral tablet
- Donepezil HCl ODT tablet

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   
   a. If yes, approve for 12 months
   
   b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Nasal Steroid Agents
#### Step Therapy Guidelines

**Affected Medication(s)**

- Beconase AQ (beclomethasone dipropionate) nasal spray
- Dymista (azelastine HCl-fluticasone propionate) nasal spray
- Nasonex (mometasone furoate) nasal spray
- Omninair (ciclesonide) nasal spray
- Patanase (olopatadine HCl) nasal spray
- Qnasl (beclomethasone dipropionate) nasal aerosol
- Qnasl Children (beclomethasone dipropionate) nasal aerosol
- Rhinocort Aqua (budesonide) nasal spray
- Veramyst (fluticasone furoate) nasal spray
- Zetonna (ciclesonide) nasal aerosol

**Step Therapy Requirements**

**Step 1 Drug(s):**

- Budesonide nasal spray
- Flunisolide nasal spray
- Fluticasone propionate nasal spray
- Triamcinolone acetonide nasal spray

**Step Therapy Criteria**

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
**Noctiva® (desmopressin acetate) Step Therapy Guidelines**

**Affected Medication(s)**
- Noctiva (desmopressin acetate) nasal spray

**Step Therapy Requirements**

**Step 1 Drug(s):**
- Desmopressin acetate oral tablet
- Flavoxate HCl oral tablet

**Step Therapy Criteria**

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# NSAID Agents
## Step Therapy Guidelines

### Affected Medication(s)
- Sprix (ketorolac tromethamine) nasal spray
- Vivlodex (meloxicam, submicronized) oral capsule

### Step Therapy Requirements

#### Step 1 Drug(s):
- Diclofenac potassium oral tablet
- Diclofenac sodium DR oral tablet
- Diclofenac sodium ER oral tablet
- Ibuprofen oral tablet
- Indomethacin oral capsule
- Meloxicam oral tablet
- Naproxen oral tablet
- Naproxen DR oral tablet
- Oxaprozin oral tablet
- Sulindac oral tablet
- Tolmetin sodium oral capsule

#### Step Therapy Criteria
1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
## Affected Medication(s)

- Onmel (itraconazole) oral tablet

## Step Therapy Requirements

### Step 1 Drug(s):

- Itraconazole oral capsule

## Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   
   b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Affected Medication(s)

- Darifenacin ER oral tablet
- Enablex (darifenacin hydrobromide) ER oral tablet
- Gelnique (oxybutynin chloride) transdermal gel pump
- Gelnique (oxybutynin chloride) transdermal gel packet
- Myrbetriq (mirabegron) ER oral tablet
- Oxytrol (oxybutynin) transdermal patch
- Toviaz (fesoterodine fumarate) ER oral tablet
- Vesicare (solifenacin succinate) oral tablet

### Step Therapy Requirements

**Step 1 Drug(s):**

- Oxybutynin chloride oral tablet
- Oxybutynin chloride ER oral tablet
- Tolterodine tartrate oral tablet
- Trospium chloride oral tablet

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   
   a. If yes, approve for 12 months
   
   b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
## Pancreatic Enzymes
### Step Therapy Guidelines

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<tbody>
<tr>
<td>• Pancreaze</td>
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<td>• Pertyze</td>
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<th>Step Therapy Requirements</th>
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<td><strong>Step 1 Drug(s):</strong></td>
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<td>• Zenpep</td>
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<th>Step Therapy Criteria</th>
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<td>1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)</td>
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<tr>
<td>a. If yes, approve for 12 months</td>
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<td>b. If no, continue to #2</td>
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<tr>
<td>2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required</td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
</tr>
<tr>
<td>b. If no, clinical review required</td>
</tr>
</tbody>
</table>
Proton Pump Inhibitor Agents
Step Therapy Guidelines

Affected Medication(s)

- Aciphex Sprinkle (rabeprazole sodium) DR oral tablet
- Dexilant (dextansoprazole) DR oral capsule
- Nexium (esomeprazole magnesium) DR oral capsule
- Nexium (esomeprazole magnesium) DR oral suspension packet
- Prevacid (lansoprazole) DR oral tablet
- Prilosec (omeprazole magnesium) DR oral suspension packet
- Protonix (pantoprazole sodium) DR oral granule packet
- Zegerid (omeprazole-sodium bicarbonate) oral packet

Step Therapy Requirements

Step 1 Drug(s):

- Lansoprazole DR oral capsule
- Omeprazole DR oral capsule
- Pantoprazole sodium DR oral tablet

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Pramipexole ER
Step Therapy Guidelines

Affected Medication(s)

- Mirapex ER (pramipexole dihydrochloride) ER oral tablet
- Pramipexole ER oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Pramipexole dihydrochloride oral tablet

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
### Affected Medication(s)

- Mirvaso (brimonidine tartrate) topical gel
- Mirvaso (brimonidine tartrate) topical gel pump
- Rhofade (oxymetazoline HCl) topical cream
- Rosadan (metronidazole-skin cleanser combination no. 23) topical cream kit
- Rosadan (metronidazole-skin cleanser combination no. 23) topical gel kit

### Step Therapy Requirements

**Step 1 Drug(s):**

- Metronidazole topical cream
- Metronidazole topical lotion
- Metronidazole topical gel pump
- Metronidazole topical gel

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Affected Medication(s)

- Proair HFA (albuterol sulfate) inhalation aerosol
- Proair RespiClick (albuterol sulfate) inhalation powder
- Proair Digihaler (albuterol sulfate) inhalation powder
- Proventil HFA (albuterol sulfate) inhalation aerosol
- Xopenex HFA (levalbuterol tartrate) inhalation aerosol

Step Therapy Requirements

Step 1 Drug(s):

- Ventolin HFA (albuterol sulfate) inhalation aerosol

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Sodium-Glucose Cotransporter-2 Inhibitors
## Step Therapy Guidelines

### Affected Medication(s)

**Step 2 Drug(s):**
- Farxiga (dapagliflozin propanediol) oral tablet
- Jardiance (empagliflozin) oral tablet
- Synjardy (empagliflozin-metformin HCl) oral tablet
- Synjardy XR (empagliflozin-metformin HCl) oral tablet
- Xigduo XR (dapagliflozin propanediol-metformin HCl) oral tablet

**Step 3 Drug(s):**
- Glyxambi (empagliflozin-linagliptin) oral tablet
- Invokamet (canagliflozin-metformin HCl) oral tablet
- Invokamet XR (canagliflozin-metformin HCl) oral tablet
- Invokana (canagliflozin) oral tablet
- Qtern (dapagliflozin propanediol-saxagliptin HCl) oral tablet
- Segluromet (ertugliflozin pidolate-metformin HCl) oral tablet
- Stegletro (ertugliflozin pidolate) oral tablet
- Steglujan (ertugliflozin pidolate-sitagliptin phosphate) oral tablet

### Step Therapy Requirements

**Step 1 Drug(s):**
- Metformin HCl oral tablet
- Metformin HCl ER tablet

**Step 2 Drug(s):**
- Farxiga (dapagliflozin propanediol) oral tablet
- Jardiance (empagliflozin) oral tablet
- Synjardy (empagliflozin-metformin HCl) oral tablet
- Synjardy XR (empagliflozin-metformin HCl) oral tablet
- Xigduo XR (dapagliflozin propanediol-metformin HCl) oral tablet

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
   b. If no, clinical review required
3. Prescription claim for ONE Step 2 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #4

4. If no claim history of Step 2 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 2 Drug is required.
   a. If yes, approve for 12 months
   b. If no, clinical review is required

**Note:**

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
**Sitavig® (acyclovir)**

**Step Therapy Guidelines**

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sitavig (acyclovir) buccal tablet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1 Drug(s):</strong></td>
</tr>
<tr>
<td>• Acyclovir oral capsule</td>
</tr>
<tr>
<td>• Acyclovir oral tablet</td>
</tr>
<tr>
<td>• Famiclovir oral tablet</td>
</tr>
<tr>
<td>• Valacyclovir HCl oral tablet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)</td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
</tr>
<tr>
<td>b. If no, continue to #2</td>
</tr>
<tr>
<td>2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required</td>
</tr>
<tr>
<td>a. If yes, approve for 12 months</td>
</tr>
<tr>
<td>b. If no, clinical review required</td>
</tr>
</tbody>
</table>

**Note:**

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### Affected Medication(s)
- Acitretin oral capsule
- Soriatane (acitretin) oral capsule

### Step Therapy Requirements

**Step 1 Drug(s):**
- Avita (tretinoin) topical cream
- Avita (tretinoin) topical gel
- Tretinoin topical cream
- Tretinoin topical gel

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

**Note:**
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## Spritam® (levetiracetam) Step Therapy Guidelines

### Affected Medication(s)
- Spritam (levetiracetam) oral tablet for suspension

### Step Therapy Requirements

#### Step 1 Drug(s):
- Levetiracetam oral tablet
- Levetiracetam oral solution
- Levetiracetam ER oral tablet

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months unless otherwise specified
   - b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, or intolerance to ONE Step 1 Drug is required
   - a. If yes, approve for 12 months unless otherwise specified
   - b. If no, clinical review required

**Note:**
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### Statin Agents
#### Step Therapy Guidelines

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fluvastatin sodium ER oral tablet</td>
</tr>
<tr>
<td>• Fluvastatin sodium oral capsule</td>
</tr>
<tr>
<td>• Livalo (pitavastatin calcium) oral tablet</td>
</tr>
<tr>
<td>• Zypitamag (pitavastatin magnesium) oral tablet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1 Drug(s):</strong></td>
</tr>
<tr>
<td>• Atorvastatin calcium oral tablet</td>
</tr>
<tr>
<td>• Lovastatin oral tablet</td>
</tr>
<tr>
<td>• Pravastatin sodium oral tablet</td>
</tr>
<tr>
<td>• Rosuvastatin calcium oral tablet</td>
</tr>
<tr>
<td>• Simvastatin oral tablet</td>
</tr>
</tbody>
</table>

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**Note:**

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# Sumaxin® (levetiracetam)
## Step Therapy Guidelines

### Affected Medication(s)
- Sumaxin CP (sulfacetamide-sulfur-skin cleanser combo no. 23) topical kit

### Step Therapy Requirements

#### Step 1 Drug(s):  
- Sodium sulfacetamide-sulfur topical cleanser

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Tetracycline Antibiotic Agents
## Step Therapy Guidelines

### Affected Medication(s)
- Doryx (doxycycline hyclate) DR oral tablet
- Doryx MPC (doxycycline hyclate) DR oral tablet
- Doxycycline hyclate DR oral tablet
- Oracea (doxycycline monohydrate) oral capsule
- Soloxide (doxycycline hyclate) DR oral tablet
- Targadox (doxycycline hyclate) oral tablet
- Ximino (minocycline HCl) ER oral capsule

### Step Therapy Requirements

#### Step 1 Drug(s):
- Doxycycline monohydrate oral capsule
- Doxycycline monohydrate oral tablet
- Minocycline HCl oral capsule
- Minocycline HCl oral tablet

#### Step Therapy Criteria
1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

### Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Affected Medication(s)

- Clindamycin phosphate-tretinoin topical gel
- Veltin (clindamycin phosphate-tretinoin) topical gel
- Ziana (clindamycin phosphate-tretinoin) topical gel

Step Therapy Requirements

Step 1 Drug(s):

- Avita (tretinoin) topical cream
- Avita (tretinoin) topical gel
- Tretinoin topical cream
- Tretinoin topical gel

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Topical Acne Agents
## Step Therapy Guidelines

### Affected Medication(s)

- Acanya (clindamycin phosphate-benzoyl peroxide) topical gel pump
- Onexton (clindamycin phosphate-benzoyl peroxide) topical gel pump

### Step Therapy Requirements

#### Step 1 Drugs:

- Clindamycin phosphate-benzoyl peroxide topical gel
- Clindamycin phosphate-benzoyl peroxide topical gel pump
- Neuac (clindamycin phosphate-benzoyl peroxide) topical gel

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   
   a. If yes, approve for 12 months
   
   b. If no, clinical review required

### Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Topical Antibiotic Agents
## Step Therapy Guidelines

### Affected Medication(s)
- Altabax 1% ointment
- Xepi 1% cream

### Step Therapy Requirements

#### Step 1 Drug(s):
- Mupirocin 2% cream
- Mupirocin 2% ointment

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

**Note:**

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## Affected Medication(s)

- Avage (tazarotene) topical cream
- Doxepin topical cream
- Eucrisa (crisaborole) topical ointment
- Tazorac (tazarotene) topical gel

## Step Therapy Requirements

### Step 1 Drug(s):

- Betamethasone dipropionate topical cream
- Betamethasone dipropionate topical lotion
- Betamethasone dipropionate topical ointment
- Betamethasone dipropionate augmented (betamethasone dipropionate-propylene glycol) topical cream
- Betamethasone dipropionate augmented (betamethasone dipropionate-propylene glycol) topical lotion
- Betamethasone dipropionate augmented (betamethasone dipropionate-propylene glycol) topical ointment
- Betamethasone valerate topical cream
- Betamethasone valerate topical lotion
- Betamethasone valerate topical ointment
- Clobetasol propionate topical cream
- Clobetasol propionate topical ointment
- Clobetasol propionate topical solution
- Clobetasol propionate topical lotion
- Desoximetasone topical cream
- Desoximetasone topical gel
- Desoximetasone topical ointment
- Fluocinonide topical cream
- Fluocinonide topical gel
- Fluocinonide topical ointment
- Fluocinonide topical solution
- Fluocinonide-E (fluocinonide-emollient base) topical cream
- Halobetasol propionate topical cream
- Halobetasol propionate topical ointment
- Tacrolimus topical ointment

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   
   a. If yes, approve for 12 months
   b. If no, clinical review required
Note:
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
Topical NSAID Agents
Step Therapy Guidelines

Affected Medication(s)

- Flector (diclofenac epolamine) topical patch
- Pennsaid (diclofenac sodium) topical solution

Step Therapy Requirements

Step 1 Drug(s):

- Diclofenac potassium oral tablet
- Diclofenac sodium DR oral tablet
- Diclofenac sodium ER oral tablet
- Ibuprofen oral tablet
- Indomethacin oral capsule
- Meloxicam oral tablet
- Naproxen oral tablet
- Naproxen DR oral tablet
- Oxaprozin oral tablet
- Sulindac oral tablet
- Tolmetin sodium oral capsule
- Diclofenac sodium topical gel

Step Therapy Criteria

1. Prescription claim for ONE prescription strength oral NSAID Step 1 Drug AND diclofenac sodium gel within the past 180 days (Note: 90 days of claims history required for authorization)
   a. If yes, approve for 12 months
   b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required
   a. If yes, approve for 12 months
   b. If no, clinical review required

Note:

Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.
# Topical Vitamin A Derivatives
## Step Therapy Guidelines

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Atralin (tretinoin) topical gel</td>
</tr>
<tr>
<td>• Differin (adapalene) topical cream</td>
</tr>
<tr>
<td>• Differin (adapalene) topical gel</td>
</tr>
<tr>
<td>• Differin (adapalene) topical gel pump</td>
</tr>
<tr>
<td>• Epiduo (adapalene-benzoyl peroxide) topical gel pump</td>
</tr>
<tr>
<td>• Retin-A (tretinoin) topical cream</td>
</tr>
<tr>
<td>• Retin-A (tretinoin) topical gel</td>
</tr>
<tr>
<td>• Retin-A-Micro (tretinoin microspheres) topical gel</td>
</tr>
<tr>
<td>• Retin-A-Micro Pump (tretinoin microspheres) topical gel</td>
</tr>
<tr>
<td>• Tazorac topical cream</td>
</tr>
<tr>
<td>• Tazorac topical gel</td>
</tr>
<tr>
<td>• Tretinoin microsphere topical gel</td>
</tr>
<tr>
<td>• Tretinoin microsphere topical gel pump</td>
</tr>
<tr>
<td>• Tretin-X (tretinoin) topical cream</td>
</tr>
<tr>
<td>• Tretin-X (tretinoin-emiclant combination no. 9-skin cleanser no.1) topical combo package</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1 Drug(s):</strong></td>
</tr>
<tr>
<td>• Adapalene topical cream</td>
</tr>
<tr>
<td>• Adapalene topical gel</td>
</tr>
<tr>
<td>• Adapalene topical gel pump</td>
</tr>
<tr>
<td>• Adapalene-benzoyl peroxide topical gel pump</td>
</tr>
<tr>
<td>• Avita (tretinoin) topical cream</td>
</tr>
<tr>
<td>• Avita (tretinoin) topical gel</td>
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<tr>
<td>• Tretinoin topical cream</td>
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<tr>
<td>1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)</td>
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<td>a. If yes, approve for 12 months</td>
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<tr>
<td>2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drugs is required</td>
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<tr>
<td>a. If yes, approve for 12 months</td>
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<td>b. If no, clinical review required</td>
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</table>
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## Tramadol Step Therapy Guidelines

### Affected Medication(s)
- ConZip (tramadol HCl) oral capsule
- Tramadol ER capsule

### Step Therapy Requirements
#### Step 1 Drug(s):
- Tramadol HCl oral tablet

### Step Therapy Criteria
1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

**Note:**
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# Triptan Agents
## Step Therapy Guidelines

### Affected Medication(s)

#### Step 2 Drug(s):
- Almotriptan malate oral tablet
- Axert (almotriptan malate) oral tablet
- Eletriptan hydrobromide oral tablet
- Frova (frovatriptan succinate) oral tablet
- Frovatriptan succinate oral tablet
- Migranal (dihydroergotamine mesylate) nasal spray
- Onzetra Xsail (sumatriptan succinate) nasal powder
- Relpax (eletriptan hydrobromide) oral tablet
- Sumatriptan succinate-naproxen sodium oral tablet
- Sumatriptan nasal spray
- Treximet (sumatriptan succinate-naproxen sodium) oral tablet

#### Step 3 Drug(s):
- Zembrace SymTouch (sumatriptan succinate) subcutaneous pen injector

### Step Therapy Requirements

#### Step 1 Drug(s):
- Naratriptan HCl oral tablet
- Rizatriptan benzoate oral tablet
- Rizatriptan benzoate orally disintegrating tablet
- Sumatriptan succinate oral tablet

#### Step 2 Drug(s):
- Almotriptan malate oral tablet
- Axert (almotriptan malate) oral tablet
- Eletriptan hydrobromide oral tablet
- Frova (frovatriptan succinate) oral tablet
- Frovatriptan succinate oral tablet
- Migranal (dihydroergotamine mesylate) nasal spray
- Onzetra Xsail (sumatriptan succinate) nasal powder
- Relpax (eletriptan hydrobromide) oral tablet
- Sumatriptan succinate-naproxen sodium oral tablet
- Sumatriptan nasal spray
- Treximet (sumatriptan succinate-naproxen sodium) oral tablet

### Step Therapy Criteria

1. Is the request for a step 2 medication?
   a. If yes continue to #2
   b. If no, continue to #4
2. Does the member have prescription claim for TWO Step 1 Drug(s) within the past 180 days? (Note: 30 days of claims history required for authorization)
   a. If yes, approve Step 2 Drug for 12 months
   b. If no, continue to #3

3. Does the member have documentation of trial, intolerance or contraindication to TWO Step 1 Drug?
   a. If yes, approve Step 2 Drug for 12 months.
   b. If no, clinical review required

4. Does the member have prescription claim for TWO Step 1 Drug(s) within the past 180 days? (Note: 90 days of claims history required for authorization)
   a. If yes, continue to #6
   b. If no, continue to #5

5. Does the member have documentation of trial, intolerance or contraindication to TWO Step 1 Drug?
   a. If yes, continue to #6
   b. If no, clinical review required

6. Does the member have prescription claim(s) for ONE Step 2 Drug(s) within the past 180 days? (Note: 30 days of claims history required for authorization)
   a. If yes, approve step 3 drug for 12 months
   b. If no, continue to #7

7. Does the member have documentation of trial, intolerance, or contraindication to ONE Step 2 Drug?
   a. If yes, approve step 3 drug for 12 months
   b. If no, clinical review is required

**Note:**
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**Zenzedi® (dextroamphetamine sulfate)**

**Step Therapy Guidelines**

<table>
<thead>
<tr>
<th>Affected Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Zenzedi (dextroamphetamine sulfate) oral tablet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step Therapy Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1 Drug(s):</strong></td>
</tr>
<tr>
<td>• Dexamphetamine HCl oral tablet</td>
</tr>
<tr>
<td>• Dextroamphetamine-amphetamine oral tablet</td>
</tr>
<tr>
<td>• Dextroamphetamine sulfate oral tablet</td>
</tr>
<tr>
<td>• Methylphenidate HCl oral tablet</td>
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**Note:**
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# Zodex® (dexamethasone)
## Step Therapy Guidelines

**Affected Medication(s)**
- Zodex (dexamethasone) oral tablet

**Step Therapy Requirements**

**Step 1 Drug(s):**
- Dexamethasone oral tablet
- Dexamethasone oral elixir

**Step Therapy Criteria**

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
   - a. If yes, approve for 12 months
   - b. If no, continue to #2

2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required
   - a. If yes, approve for 12 months
   - b. If no, clinical review required

**Note:**
Medication step therapy guidelines are used as a basis for making coverage decisions and do not serve as medical advice. Coverage of medications is subject to plan provisions. Additional coverage restrictions not listed in the guidelines may apply.