



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)
<ul style="list-style-type: none">• Adzenys ER oral suspension• Dyanavel XR oral suspension
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Dextroamphetamine sulfate oral solution• Methylphenidate HCl oral solution
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



Amrix® (cyclobenzaprine HCl) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Amrix (cyclobenzaprine HCl) ER oral capsuleCyclobenzaprine ER oral capsule
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Cyclobenzaprine HCl oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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

Affected Medication(s)
<ul style="list-style-type: none">• Bevyxxa (betrixaban maleate) oral capsule• Pradaxa (dabigatran etexilate mesylate) oral capsule• Savaysa (edoxaban tosylate) oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Eliquis (apixaban) oral tablet• Xarelto (rivaroxaban) oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



Antidepressant Agents Step Therapy Guidelines

Affected Medication(s)

- Desvenlafaxine ER oral tablet
- Desvenlafaxine fumarate ER oral tablet
- Fetzima (levomilnacipran HCl) SA oral capsule
- Forfivox 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.



Antiglaucoma Agents Step Therapy Guidelines

Affected Medication(s)

- Azopt (brinzolamide) ophthalmic drops
- Cosopt PF (dorzolamide HCl-timolol maleate) ophthalmic dropperette
- Lumigan (bimatoprost) ophthalmic drops
- Rescula (unoprostone isopropyl) ophthalmic drops
- Rhopressa (netarsudil mesylate) ophthalmic drops
- Travatan Z (travoprost) ophthalmic drops
- Vyzulta (latanoprostene bunod) ophthalmic drops
- Xelpros (lantanoprost) ophthalmic emulsion
- Zioptan (tafluprost) ophthalmic dropperette

Step Therapy Requirements

Step 1 Drug(s):

- Brimonidine drops
- Carteolol drops
- Dorzolamide drops
- Latanoprost drops
- Levobunolol drops
- Timolol maleate drops

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.



Antihypertensive Agents Step Therapy Guidelines

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
- Irbesartan oral tablet
- Irbesartan-hydrochlorothiazide oral tablet
- Losartan potassium oral tablet
- Losartan-hydrochlorothiazide oral tablet
- Olmesartan medoxomil oral tablet
- Olmesartan-hydrochlorothiazide
- 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)

- Caplyta (lumateperone) oral capsule
- Fanapt (iloperidone) oral tablet
- Invega (paliperidone) ER oral tablet
- Paliperidone ER oral tablet
- Rexulti (brexpiprazole) oral tablet
- Saphris (asenapine maleate) sublingual tablet
- Secuado (asenapine) transdermal

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

Affected Medication(s)
<ul style="list-style-type: none">• Clindacin ETZ (clindamycin phosphate) topical swab• Clindacin P (clindamycin phosphate) topical swab
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Clindamycin phosphate topical gel• Clindamycin phosphate topical solution• Clindamycin phosphate topical lotion
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



Constipation Agents Step Therapy Guidelines

Affected Medication(s)

Step 2 Drug(s)

- Linzess (linaclotide) oral capsule
- Movantik (naloxegol) oral tablet
- Symproic(naldemedine) 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(naldemedine) 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.



- | |
|---|
| <ul style="list-style-type: none">a. If yes, approve for 12 monthsb. 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)
<ul style="list-style-type: none">• Carvedilol ER (carvedilol phosphate) oral capsule• Coreg CR (carvedilol phosphate) oral capsule
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Bisoprolol fumarate oral tablet• Carvedilol oral tablet• Metoprolol succinate ER oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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

Affected Medication(s)
<ul style="list-style-type: none">Dificid (fidaxomicin) oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Metronidazole oral tabletVancomycin HCl oral capsule
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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.



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.



Glucagon-Like Peptide-1 Agonist Agents Step Therapy Guidelines

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
- Rybelsus (semaglutide) oral tablet

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. 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 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



- b. If no, continue to #3
- 3. Does the member have documentation of trial, intolerance or contraindication to ONE 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 ONE 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 ONE Step 1 Drug?
 - a. If yes, continue to #6
 - b. If no, clinical review required
- 6. Does the member have prescription claim(s) for TWO Step 2 Drug(s) within the past 180 days? (Note: 90 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 TWO Step 2 Drugs?
 - a. If yes, approve step 3 drug 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)
<ul style="list-style-type: none">AirDuo DigiHaler (fluticasone propionate-salmeterol xinafoate) inhalation powderAirDuo RespiClick (fluticasone propionate-salmeterol xinafoate) inhalation powderDulera (mometasone furoate/formoterol fumarate) inhalation powder
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Advair HFA (fluticasone propionate-salmeterol xinafoate) inhalation aerosolBreo Ellipta (fluticasone furoate-vilanterol trifenate) inhalation powderSymbicort (budesonide/formoterol fumarate) inhalation powder
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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)

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

Step Therapy Requirements

Step 1 Drug(s):

- Estazolam oral tablet
- Eszopiclone oral tablet
- Temazepam oral capsule
- 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.



Istalol® (timolol maleate) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Istalol (timolol maleate) ophthalmic drops
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Timolol maleate ophthalmic drops
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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)
<ul style="list-style-type: none">Dutasteride-tamsulosin HCl oral capsuleJalyn (dutasteride-tamsulosin HCl) oral capsule
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Finasteride oral tabletTamsulosin HCl oral capsule
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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 Beta Agonist & Long Acting Antimuscarinic Combination Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Stiolto Respimat (tiotropium bromide-olodaterol HCl) inhalation spray
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Incruse Ellipta (umeclidinium bromide) inhalation powder
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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 Beta Agonist Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Arcapta Neohaler (indacaterol maleate) inhalation powder• Brovana (arformoterol tartrate) inhalation solution• Perforomist (formoterol fumarate) inhalation solution
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Serevent Diskus (salmeterol xinafoate) inhalation powder• Striverdi Respimat (olodaterol) inhaler spray
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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 Antimuscarinic Agents Step Therapy Guidelines

Affected Medication(s)

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

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.



Miscellaneous Oral Diabetic Agents Step Therapy Guidelines

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

I Affected Medication(s)
<ul style="list-style-type: none">• Memantine ER oral capsule• Namenda XR (memantine HCl) oral capsule
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Memantine HCl oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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)
<ul style="list-style-type: none">Namzaric (memantine HCl-donepezil HCl) oral capsule
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Memantine HCl oral tabletDonepezil HCl oral tabletDonepezil HCl ODT tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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)

- azelastin-fluticasone nasal spray
- Beconase AQ (beclomethasone dipropionate) nasal spray
- Dymista (azelastine HCl-fluticasone propionate) nasal spray
- Nasonex (mometasone furoate) nasal spray
- Omnaris (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)
<ul style="list-style-type: none">Noctiva (desmopressin acetate) nasal spray
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Desmopressin acetate oral tabletFlavoxate HCl oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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)

- Ketoprofen oral capsule
- Ketoprofen ER oral capsule
- Meclofenamate oral capsule
- Sprix (ketorolac tromethamine) nasal spray

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
- Piroxicam oral capsule
- Sulindac 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.



Onmel® (itraconazole) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Onmel (itraconazole) oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Itraconazole oral capsule
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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.



Overactive Bladder Agents Step Therapy Guidelines

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

Affected Medication(s)

- Pancreaze
- Pertyze
- Viokace

Step Therapy Requirements

Step 1 Drug(s):

- Creon
- Zenpep

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



Proton Pump Inhibitor Agents Step Therapy Guidelines

Affected Medication(s)

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

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)
<ul style="list-style-type: none">Mirapex ER (pramipexole dihydrochloride) ER oral tabletPramipexole ER oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Pramipexole dihydrochloride oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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.



Rosacea Agents Step Therapy Guidelines

Affected Medication(s)

- ivermectin 1% cream
- Mirvaso (brimonidine tartrate) topical gel
- Mirvaso (brimonidine tartrate) topical gel pump
- Rhofade (oxymetazoline HCl) topical cream
- Soolantra (ivermectin) 1% cream
- Zilxi (minocycline) topical foam

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.



Short-Acting Beta Agonist Agents Step Therapy Guidelines

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

Affected Medication(s)
<ul style="list-style-type: none">Sitavig (acyclovir) buccal tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Acyclovir oral capsuleAcyclovir oral tabletFamciclovir oral tabletValacyclovir HCl oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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.



Spritam® (levetiracetam) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Spritam (levetiracetam) oral tablet for suspension
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Levetiracetam oral tabletLevetiracetam oral solutionLevetiracetam ER oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 months unless otherwise specifiedIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, or intolerance to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 months unless otherwise specifiedIf 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.



Statin Agents Step Therapy Guidelines

Affected Medication(s)

- Fluvastatin sodium ER oral tablet
- Fluvastatin sodium oral capsule
- Lescol (fluvastatin) oral capsule
- Lescol XL (fluvastatin) oral tablet
- Livalo (pitavastatin calcium) oral tablet
- Zypitamag (pitavastatin magnesium) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Atorvastatin calcium oral tablet
- Lovastatin oral tablet
- Pravastatin sodium oral tablet
- Rosuvastatin calcium oral tablet
- Simvastatin 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.



Sumaxin® Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Sumaxin CP (sulfacetamide-sulfur-skin cleanser combo no. 23) topical kit
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Sodium sulfacetamide-sulfur topical cleanser
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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
- Minocycline HCl ER oral capsule
- 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.



Topical Acne Agents Step Therapy Guidelines

Affected Medication(s)

- Acanya (clindamycin phosphate-benzoyl peroxide) topical gel pump
- Clindamycin phosphate-tretinoin topical gel
- Onexton (clindamycin phosphate-benzoyl peroxide) topical gel pump
- Veltin (clindamycin phosphate-tretinoin) topical gel
- Ziana (clindamycin phosphate-tretinoin) topical gel

Step Therapy Requirements

Step 1 Drugs:

- Avita (tretinoin) topical cream
- Avita (tretinoin) topical gel
- clindamycin phosphate-benzoyl peroxide topical gel
- clindamycin phosphate-benzoyl peroxide topical gel pump
- Neuac (clindamycin phosphate-benzoyl peroxide) topical gel
- tretinoin topical cream
- tretinoin topical gel

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.



Topical Antibiotic Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Altabax 1% ointment• Xepi 1% cream
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Mupirocin 2% cream• Mupirocin 2% ointment
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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 Anti-Inflammatory Agents Step Therapy Guidelines

Affected Medication(s)

- calcitriol ointment
- calcipotriene 0.005% foam
- doxepin topical cream
- Eucrisa (crisaborole) topical ointment
- Duobrii (halobetasol/tazarotene) topical lotion
- Prudoxin (doxepin) 5% cream
- Sorilux (calcipotriene) 0.005% foam
- Vectical (calcitriol) ointment
- Zonalon (doxepin) 5% cream

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 Vitamin A Derivatives Step Therapy Guidelines

Affected Medication(s)

- Akliel (trifarotene) topical cream
- Arazlo (tazarotene) topical lotion
- Atralin (tretinoin) topical gel
- Avage (tazarotene) topical cream
- Epiduo (adapalene-benzoyl peroxide) topical gel pump
- Epiduo Forte (adapalene-benzoyl peroxide) topical gel pump
- Fabior (tazarotene) topical foam
- Retin-A-Micro (tretinoin microspheres) topical gel
- Retin-A-Micro Pump (tretinoin microspheres) topical gel
- Tazorac (tazarotene) topical cream
- Tazorac (tazarotene) topical gel
- tazarotene topical cream
- tretinoin microsphere topical gel
- tretinoin microsphere topical gel pump
- Tretin-X (tretinoin) topical cream
- Tretin-X (tretinoin-emollient combination no. 9-skin cleanser no.1) topical combo package

Step Therapy Requirements

Step 1 Drug(s):

- Adapalene topical cream
- Adapalene topical gel
- Adapalene topical gel pump
- Adapalene-benzoyl peroxide topical gel pump
- 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 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.



Tramadol Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• ConZip (tramadol HCl) oral capsule• Tramadol ER capsule
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Tramadol HCl oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



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:

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.



Zenedi® (dextroamphetamine sulfate) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Zenedi (dextroamphetamine sulfate) oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Dexmethylphenidate HCl oral tabletDextroamphetamine-amphetamine oral tabletDextroamphetamine sulfate oral tabletMethylphenidate HCl oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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.



Zodex[®] (dexamethasone) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Zodex (dexamethasone) oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Dexamethasone oral tabletDexamethasone oral elixir
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf 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.