



## Actinic Keratosis Agents Step Therapy Guidelines

### Affected Medication(s)

- Diclofenac sodium topical gel
- Fluorouracil 0.5% topical cream
- Imiquimod 3.75% topical cream
- Imiquimod 3.75% topical cream pump
- Klisyri (tirbanibulin) topical ointment
- 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 5% topical cream pack
- Fluorouracil 5% topical cream

### 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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## Amrix® (cyclobenzaprine HCl) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>Amrix (cyclobenzaprine HCl) ER oral capsule</li><li>Cyclobenzaprine ER oral capsule</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>Cyclobenzaprine HCl oral tablet</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>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"><li>If yes, approve for 12 months</li><li>If no, continue to #2</li></ol></li><li>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"><li>If yes, approve for 12 months</li><li>If no, clinical review required</li></ol></li></ol>

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## Anticoagulant Agents Step Therapy Guidelines

### Affected Medication(s)

- dabigatran oral capsule
- Pradaxa (dabigatran etexilate mesylate) oral capsule
- Savaysa (edoxaban tosylate) oral tablet

### Step Therapy Requirements

#### Step 1 Drug(s):

- Eliquis (apixaban) oral tablet
- Xarelto (rivaroxaban) oral tablet

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drugs 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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## Antidepressant Agents Step Therapy Guidelines

### Affected Medication(s)

- Desvenlafaxine ER oral tablet
- Desvenlafaxine fumarate ER oral tablet
- Fetzima (levomilnacipran HCl) SA oral capsule
- Forfiv XL (bupropion HCl) ER oral tablet
- Marplan (isocarboxazid) oral tablet
- Pexeva (paroxetine mesylate) oral tablet
- Trimipramine maleate oral capsule
- Trintellix (vortioxetine hydrobromide) oral tablet
- Viiibryd (vilazodone HCl) oral tablet
- vilazodone 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

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## Antiglaucoma Agents Step Therapy Guidelines

### Affected Medication(s)

- Azopt (brinzolamide) ophthalmic drops
- Cosopt PF (dorzolamide HCl-timolol maleate) ophthalmic dropperette
- Istalol 0.5% (timolol 0.5%) eye drops
- Lumigan (bimatoprost) ophthalmic drops
- Rhopressa (netarsudil mesylate) ophthalmic drops
- Travatan Z (travoprost) ophthalmic drops
- Vyzulta (latanoprostene bunod) ophthalmic drops
- Xelpros (latanoprost) 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

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## Antihypertensive Agents Step Therapy Guidelines

### Affected Medication(s)

- Aliskiren hemifumarate
- 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
- Edarbi (azilsartan medoxomil) oral tablet
- Edarbyclor (azilsartan medoxomil-chlorthalidone) oral 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
- Trandolapril-verapamil oral tablet
- Tribenzor (olmesartan medoxomil-amlodipine besylate-hydrochlorothiazide) 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

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## Aptiom® (eslicarbazepine), Xcopri® (cenobamate) Step Therapy Guidelines

### Affected Medication(s)

- Aptiom (eslicarbazepine) oral tablet
- Xcopri (cenobamate) oral tablet

### Step Therapy Requirements

#### Step 1 Drug(s):

- Carbamazepine oral tablet
- Gabapentin oral capsule
- Oxcarbazepine oral tablet
- Phenobarbital oral tablet
- Phenytoin oral capsule
- Pregabalin oral capsule
- Primidone oral tablet
- Tiagabine oral tablet
- Vimpat (lacosamide) oral tablet

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drugs 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 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drugs are required
  - a. If yes, approve for 12 months
  - b. If no, clinical review required

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## 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
- Asenapine sublingual tablet
- Secuado (asenapine) transdermal

### Step Therapy Requirements

#### Step 1 Drug(s):

- Aripiprazole oral tablet
- 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

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## 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.



## 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
- lubiprostone oral capsule
- Motegrity (prucalopride) oral tablet
- Trulance (plecanatide) oral tablet

### Step Therapy Requirements

#### Step 1 Drug(s):

- polyethylene glycol 3350 powder
- lactulose solution

#### 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 ONE 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 ONE Step 2 Drugs required.
  - a. If yes, approve for 12 months
  - b. If no, clinical review required

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## Coreg CR<sup>®</sup> (carvedilol phosphate) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>• Carvedilol ER (carvedilol phosphate) oral capsule</li><li>• Coreg CR (carvedilol phosphate) oral capsule</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>• Bisoprolol oral tablet</li><li>• Carvedilol oral tablet</li><li>• Metoprolol succinate ER oral tablet</li><li>• Nebivolol oral tablet</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>1. Prescription claim for TWO Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, continue to #2</li></ol></li><li>2. If no claim history of Step 1 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, clinical review required</li></ol></li></ol>

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## Dificid® (fidaxomicin) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>• Dificid oral tablet</li><li>• Dificid oral suspension</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>• Vancomycin HCl</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>1. Prescription claim for ONE Step 1 Drug within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, continue to #2</li></ol></li><li>2. If no claim history of Step 1 Drug, documentation of trial, intolerance or contraindication to ONE Step 1 Drugs is required<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, clinical review required</li></ol></li></ol>

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## Dipeptidyl Peptidase-4 Enzyme Inhibitor Agents Step Therapy Guidelines

### Affected Medication(s)

#### Step 2 Drug(s):

- Januvia (sitagliptin phosphate) oral tablet
- Janumet (sitagliptin phosphate-metformin HCl) oral tablet
- Janumet XR (sitagliptin phosphate-metformin HCl) oral tablet
- 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
- Kazano (alogliptin benzoate-metformin HCl) oral tablet
- 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
- Nesina (alogliptin) oral tablet

### Step Therapy Requirements

#### Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER oral tablet

#### Step 2 Drug(s):

- Januvia (sitagliptin phosphate) oral tablet
- Janumet (sitagliptin phosphate-metformin HCl) oral tablet
- Janumet XR (sitagliptin phosphate-metformin HCl) oral tablet
- Jentadueto (linagliptin-metformin HCl) oral tablet
- Jentadueto XR (linagliptin-metformin HCl) oral tablet
- Tradjenta (linagliptin) 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 ONE Step 1 Drug 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 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 Drugs contain different DPP4 inhibitors 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 contain different DPP4 inhibitors?
    - a. If yes, approve Step 3 drug for 12 months
    - b. If no, clinical review is required

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## Dry Eye Agents Step Therapy Guidelines

### Affected Medication(s)

- Restasis Ophthalmic Emulsion
- Restasis MultiDose Emulsion
- Xiidra Ophthalmic Solution

### Step Therapy Requirements

#### Step 1 Drug(s):

- Cyclosporine Ophthalmic Solution

### Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug 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, 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

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## Glucagon-Like Peptide-1 Agonist Agents Step Therapy Guidelines

### Affected Medication(s)

#### Step 2 Drug(s):

- Trulicity (dulaglutide) subcutaneous pen injector
- Victoza 2-Pak (liraglutide) subcutaneous pen injector
- Victoza 3-Pak (liraglutide) subcutaneous pen injector
- Ozempic (semaglutide) subcutaneous pen injector
- Rybelsus (semaglutide) oral tablet
- Mounjaro (tirzepatide) subcutaneous pen

#### Step 3 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

### Step Therapy Requirements

#### Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER tablet

#### Step 2 Drug(s):

- Trulicity (dulaglutide) subcutaneous pen injector
- Victoza 2-Pak (liraglutide) subcutaneous pen injector
- Victoza 3-Pak (liraglutide) subcutaneous pen injector
- Ozempic (semaglutide) subcutaneous pen injector
- Rybelsus (semaglutide) oral tablet
- Mounjaro (tirzepatide) subcutaneous pen

### 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

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## Inhaled Corticosteroid- Long Acting Beta Agonist Combination Agents Step Therapy Guidelines

### Affected Medication(s)

- Advair HFA (fluticasone propionate-salmeterol xinafoate) inhalation aerosol
- AirDuo DigiHaler (fluticasone propionate-salmeterol xinafoate) inhalation powder
- Dulera (mometasone furoate/formoterol fumarate) inhalation powder

### Step Therapy Requirements

#### Step 1 Drug(s):

- AirDuo RespiClick (fluticasone propionate-salmeterol) inhalation powder
- Fluticasone propionate-salmeterol inhaler
- Breo Ellipta (fluticasone furoate-vilanterol) inhalation powder
- Fluticasone furoate-vilanterol inhaler
- Symbicort (budesonide/formoterol fumarate) inhalation powder
- Budesonide-formoterol fumarate inhaler

### Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drugs 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 Drugs, 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:**

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## Insomnia Agents Step Therapy Guidelines

### Affected Medication(s)

- Dayvigo (lemborexant) oral tablet
- Edluar (zolpidem tartrate) sublingual tablet
- Zolpidem tartrate sublingual tablet (Intermezzo)
- Rozerem (ramelteon) oral tablet
- Ramelteon oral tablet
- Silenor (doxepin HCl) oral tablet
- Doxepin 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:**

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## Long-Acting Beta Agonist & Long Acting Antimuscarinic Combination Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>Stiolto Respimat (tiotropium bromide-olodaterol HCl) inhalation spray</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>Incruse Ellipta (umeclidinium bromide) inhalation powder</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>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"><li>If yes, approve for 12 months</li><li>If no, continue to #2</li></ol></li><li>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"><li>If yes, approve for 12 months</li><li>If no, clinical review required</li></ol></li></ol>

### **Note:**

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## Long-Acting Beta Agonist Agents Step Therapy Guidelines

### Affected Medication(s)

- Brovana (arformoterol tartrate) inhalation solution
- arformoterol tartrate inhalation solution
- Perforomist (fomoterol fumerate) inhalation solution
- formoterol fumerate 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 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, 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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## Long-Acting Antimuscarinic Agents Step Therapy Guidelines

### 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
- Semglee (insulin glargine) subcutaneous vial
- Semglee (insulin glargine) 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
- Oxymorphone 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
- Oxycodone HCl 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.



## Lyrica® CR (pregabalin) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>• Lyrica CR (pregabalin) oral tablet</li><li>• Pregabalin CR tablet</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>• Duloxetine HCl DR oral capsule</li><li>• Gabapentin oral capsule</li><li>• Gabapentin oral solution</li><li>• Gabapentin oral tablet</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>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"><li>a. If yes, approve for 12 months</li><li>b. If no, continue to #2</li></ol></li><li>2. If 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"><li>a. If yes, approve for 12 months</li><li>b. If no, clinical review required</li></ol></li></ol>

**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)

- Dymista (azelastine HCl-fluticasone propionate) nasal spray
- Azelastine-fluticasone nasal spray
- Ryaltris (olopatadine-mometasone) spray

### Step Therapy Requirements

#### Step 1 Drug(s):

- Flunisolide nasal spray
- Fluticasone propionate nasal spray
- Olopatadine nasal 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 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"><li>Noctiva (desmopressin acetate) nasal spray</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>Desmopressin acetate oral tablet</li><li>Flavoxate HCl oral tablet</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>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"><li>If yes, approve for 12 months</li><li>If no, continue to #2</li></ol></li><li>If 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"><li>If yes, approve for 12 months</li><li>If no, clinical review required</li></ol></li></ol>

**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
- Oxaprozin oral tablet
- 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
- Nabumetone tablet
- Naproxen oral tablet
- Naproxen DR 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:**

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## Ongentys (opicapone) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>Ongentys oral capsules</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>entacapone</li><li>pramipexole</li><li>ropinirole</li><li>rasagline</li><li>selegiline capsule or tablet</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>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"><li>If yes, approve for 12 months</li><li>If no, continue to #2</li></ol></li><li>If no claim history of TWO Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none"><li>If yes, approve for 12 months</li><li>If no, clinical review required</li></ol></li></ol>

**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
- fesoterodine fumarate ER oral tablet
- Gelnique (oxybutynin chloride) transdermal gel packet
- Gemtesa (vibegron) oral tablet
- Myrbetriq (mirabegron) ER suspension
- Myrbetriq (mirabegron) ER oral tablet
- Oxytrol (oxybutynin) transdermal patch
- Toviaz (fesoterodine fumarate) ER oral tablet
- Vesicare LS (solifenacin succinate) oral suspension

### Step Therapy Requirements

#### Step 1 Drug(s):

- Oxybutynin chloride oral tablet
- Oxybutynin chloride ER oral tablet
- Tolterodine tartrate oral tablet
- Trospium chloride oral tablet
- Solifenacin succinate 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 (lipase/protase/amylase) capsule
- Pertyze (lipase/protase/amylase) capsule
- Viokace (lipase/protase/amylase) capsule

### Step Therapy Requirements

#### Step 1 Drug(s):

- Creon (lipase/protase/amylase) capsule
- Zenpep (lipase/protase/amylase) 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



## Proton Pump Inhibitor Agents Step Therapy Guidelines

### Affected Medication(s)

- Aciphex Sprinkle (rabeprazole sodium) DR oral capsule
- rabeprazole sprinkle DR oral capsule
- Aciphex (rabeprazole sodium) DR oral tablet
- rabeprazole DR oral tablet
- Dexilant (dexlansoprazole) DR oral capsule
- 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

### 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:**

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## Rosacea Agents Step Therapy Guidelines

### Affected Medication(s)

- Epsolay (benzoyl peroxide) 5% cream pump
- 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
- Azelaic acid 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:**

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## 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
- Trijardy XR (empagliflozin-linagliptin-metformin) 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
- Trijardy XR (empagliflozin-linagliptin-metformin) oral tablet
- Xigduo XR (dapagliflozin propanediol-metformin HCl) oral tablet

Note: SGLT-2 Inhibitors with non-diabetic FDA approved indications (i.e. heart failure with reduced ejection fraction (HFrEF) and chronic kidney disease (CKD)) do not require trial, intolerance or contraindication to metformin prior to coverage

### 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

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Effective Date: 1/1/19, 5/1/21, 3/1/22



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 ONE 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 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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## Sitavig® (acyclovir) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>Sitavig (acyclovir) buccal tablet</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>Acyclovir oral capsule</li><li>Acyclovir oral tablet</li><li>Famciclovir oral tablet</li><li>Valacyclovir HCl oral tablet</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>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"><li>If yes, approve for 12 months</li><li>If no, continue to #2</li></ol></li><li>If 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"><li>If yes, approve for 12 months</li><li>If no, clinical review required</li></ol></li></ol>

**Note:**

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## Statin Agents Step Therapy Guidelines

### Affected Medication(s)

- Ezallor Sprinkle (rosuvastatin) oral capsule
- 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:**

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## Tetracycline Antibiotic Agents Step Therapy Guidelines

### Affected Medication(s)

- Doryx (doxycycline hyclate) DR oral tablet
- Doryx MPC (doxycycline hyclate) DR oral tablet
- Doxycycline 50mg tablet
- Doxycycline hyclate DR oral tablet
- Doxycycline IR-DR oral capsule
- Coremino ER (minocycline ER) oral tablet
- Minocycline HCl ER oral capsule
- Minocycline ER oral tablets
- Minolira ER (minocycline ER) oral tablets
- Oracea (doxycycline monohydrate) oral capsule
- Solodyn ER (minocycline ER) oral tablet
- Targadox (doxycycline) oral tablet
- Ximino (minocycline HCl) ER oral capsule

### Step Therapy Requirements

#### Step 1 Drug(s):

- 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
- Winlevi (clascoterone) topical cream
- 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"><li>• Altabax 1% ointment</li><li>• Xepi 1% cream</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>• Mupirocin 2% cream</li><li>• Mupirocin 2% ointment</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>1. Prescription claim for ONE Step 1 Drug within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, continue to #2</li></ol></li><li>2. If no claim history of Step 1 Drug, documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, clinical review required</li></ol></li></ol>

**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)

- adapalene-benzoyl peroxide (0.3%-2.5%) topical gel pump
- 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 0.3%-benzoyl peroxide 2.5%) 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
- tazarotene topical gel
- tretinoin microsphere topical gel
- tretinoin microsphere topical gel pump
- Tretin-X (tretinoin) topical cream

### Step Therapy Requirements

#### Step 1 Drug(s):

- 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 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.

Last Reviewed: 10/3/18, 3/18/20, 7/15/20, 11/18/20, 5/19/21, 7/21/21, 1/19/22  
Effective Date: 1/1/19, 5/1/20, 8/15/20, 12/15/20, 7/1/21, 9/1/21, 3/1/22



## Tramadol Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>• ConZip (tramadol HCl) oral capsule</li><li>• Tramadol ER capsule</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>• Tramadol HCl oral tablet</li><li>• Tramadol HCl ER oral tablet</li></ul>
Step Therapy Criteria
<ol style="list-style-type: none"><li>1. Prescription claim for TWO Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, continue to #2</li></ol></li><li>2. If no claim history of Step 1 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none"><li>a. If yes, approve for 12 months</li><li>b. If no, clinical review required</li></ol></li></ol>

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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
- Zolmitriptan nasal spray
- Zolmitriptan oral disintegrating tablet

#### Step 3 Drug(s):

- Zembrace SymTouch (sumatriptan succinate) subcutaneous pen injector
- Tosymra (sumatriptan) nasal spray

### 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
- Dihydroergotamine mesylate nasal spray
- Onzetra Xsail (sumatriptan succinate) nasal powder
- Relpax (eletriptan hydrobromide) oral tablet
- Sumatriptan succinate-naproxen sodium oral tablet
- Sumatriptan nasal spray
- 
- Zolmitriptan nasal spray
- Zolmitriptan oral disintegrating tablet

### Step Therapy Criteria

Last Reviewed: 10/3/18, 11/20/19, 11/18/20, 1/19/22. 3/16/22

Effective Date: 1/1/19, 12/15/20, 3/1/22, 5/1/22



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

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