



## Actinic Keratosis Agents Step Therapy Guidelines

### Affected Medication(s)

- Diclofenac 3% topical gel
- Carac (fluorouracil) 0.5% topical cream
- Fluorouracil 0.5% topical cream
- Tolak (fluorouracil) 4% topical cream
- Fluoroplex (fluorouracil) 1% topical cream
- Klisyri (tirbanibulin) topical ointment
- Zyclara (imiquimod) topical cream pack
- Imiquimod 3.75% topical cream
- Zyclara (imiquimod) topical cream metered dose pump
- Imiquimod 3.75% topical cream 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

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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
- Trimipramine maleate oral capsule
- Trintellix (vortioxetine hydrobromide) oral tablet
- Viibryd (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)

- Alphagan P 0.1% drops
- Alphagan P 0.15% eye drops
- Azopt (brinzolamide) ophthalmic drops
- Betimol eye drops
- Betoptic s 0.25% eye drops
- Brimonidine tartrate 0.15% drops
- Brimonidine-timolol 0.2%-0.5%
- Brinzolamide ophthalmic drops
- Combigan 0.2%-0.5% eye drops
- Cosopt PF (dorzolamide HCl-timolol maleate) ophthalmic dropperette
- Dorzolamide HCl-timolol maleate PF ophthalmic dropperette
- Iopidine 1% eye drops
- Istalol 0.5% (timolol 0.5%) eye drops
- Lumigan (bimatoprost) ophthalmic drops
- Rhopressa (netarsudil mesylate) ophthalmic drops
- Simbrinza eye drop
- Timolol maleate 0.25% and 0.5% eye drops (Timoptic Ocudose generic)
- Timoptic 0.25 and 0.5% Ocudose drops Travatan Z (travoprost) ophthalmic drops
- Travoprost ophthalmic drops
- Vyzulta (latanoprostene bunod) ophthalmic drops
- Xelpros (latanoprost) ophthalmic emulsion
- Zioptan (tafluprost) ophthalmic dropperette
- Tafluprost ophthalmic dropperette

### Step Therapy Requirements

#### Step 1 Drug(s):

- Brimonidine drops
- Carteolol drops
- Dorzolamide drops
- Latanoprost drops
- Levobunolol drops
- Timolol maleate drops (Timoptic generic)

### 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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Last Reviewed: 10/3/18, 3/20/19, 9/16/20, 11/17/21, 3/17/23, 11/20/23

Effective Date: 1/1/19, 5/1/19, 11/15/20, 1/1/22, 6/1/23, 2/1/24



## 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
- Kaspargo (metoprolol) oral sprinkle
- 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<sup>®</sup> (eslicarbazepine), Xcopri<sup>®</sup> (cenobamate) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>• Aptiom (eslicarbazepine) oral tablet</li><li>• Xcopri (cenobamate) oral tablet</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>• Carbamazepine oral tablet</li><li>• Gabapentin oral capsule</li><li>• Lacosamide oral tablet</li><li>• Oxcarbazepine oral tablet</li><li>• Phenobarbital oral tablet</li><li>• Phenytoin oral capsule</li><li>• Pregabalin oral capsule</li><li>• Primidone oral tablet</li><li>• Tiagabine oral tablet</li><li>• Vimpat (lacosamide) 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 are 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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## 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

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## 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® (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>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>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, documentation of trial, intolerance or contraindication to ONE 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>

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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
- Saxagliptin hcl oral tablet
- Saxagliptin-metformin hcl ER oral tablet
- Zituvio (sitagliptin) 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)
<ul style="list-style-type: none"><li>• Restasis MultiDose Emulsion</li><li>• Verkazia Ophthalmic Emulsion</li><li>• Xiidra Ophthalmic Solution</li></ul>
Step Therapy Requirements
<b>Step 1 Drug(s):</b> <ul style="list-style-type: none"><li>• Cyclosporine Ophthalmic Solution</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>

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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):

- 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
- Fluticasone propionate-salmeterol xinafoate inhalation aerosol

### 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

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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)
- Silenor (doxepin HCl) oral tablet
- Doxepin oral tablet

### Step Therapy Requirements

#### Step 1 Drug(s):

- Estazolam oral tablet
- Eszopiclone oral tablet
- Ramelteon 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

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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:**

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

### 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
- Basaglar Tempo U-100 (insulin glargine) subcutaneous insulin pen
- Levemir (insulin detemir) subcutaneous vial
- Levemir Flexpen (insulin detemir) subcutaneous insulin pen
- Semglee YFGN (insulin glargine-yfgn) subcutaneous vial
- Semglee YFGN (insulin glargine-yfgn) subcutaneous pen
- Tresiba Flextouch U-100 (insulin degludec) subcutaneous insulin pen
- Tresiba Flextouch U-200 (insulin degludec) subcutaneous insulin pen
- Tresiba U-100 subcutaneous vial
- Toujeo Max Solostar (insulin glargine) subcutaneous insulin pen
- Insulin glargine Max Solostar subcutaneous insulin pen
- Toujeo Solostar (insulin glargine) subcutaneous insulin pen
- Insulin glargine Solostar subcutaneous insulin pen

### Step Therapy Requirements

#### Step 1 Drug(s):

- Insulin glargine-yfgn subcutaneous vial
- Insulin glargine-yfgn subcutaneous pen
- Rezvoglar subcutaneous kwikpen
- Insulin glargine subcutaneous vial
- Insulin glargine subcutaneous pen
- Insulin degludec subcutaneous vial
- Insulin degludec U-100 subcutaneous pen
- Insulin degludec U-200 subcutaneous 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.



## 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
- 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:**

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.



## Ongentys (opicapone), Xadago (safinamide) Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none"><li>• Ongentys oral capsule</li><li>• Xadago oral tablet</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>• Selegiline capsule or 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 TWO Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug(s) 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.



## 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
- Trospium ER oral capsule
- 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/protease/amylase) capsule
- Pertzye (lipase/protease/amylase) capsule
- Viokace (lipase/protease/amylase) capsule

### Step Therapy Requirements

#### Step 1 Drug(s):

- Creon (lipase/protease/amylase) capsule
- Zenpep (lipase/protease/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 sprinkle capsule
- Dexilant (dexlansoprazole) DR oral capsule
- dexlansoprazole DR oral capsule
- Nexium (esomeprazole magnesium) DR oral suspension packet
- esomeprazole DR oral suspension packet
- Prevacid (lansoprazole) DR oral tablet
- lansoprazole ODT tablet
- Prilosec (omeprazole magnesium) DR oral suspension packet
- Protonix (pantoprazole sodium) DR oral granule packet
- pantoprazole DR oral granule packet

### Step Therapy Requirements

#### Step 1 Drug(s):

- esomeprazole DR oral capsule
- lansoprazole DR oral capsule
- omeprazole DR oral capsule
- pantoprazole sodium DR oral tablet
- rabeprazole 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
- Finacea (azelaic acid) 15% foam
- Metro lotion (metronidazole) 0.75% lotion
- Metronidazole 0.75% lotion
- Mirvaso (brimonidine tartrate) topical gel pump
- Brimonidine tartrate topical gel pump
- Rhofade (oxymetazoline HCl) topical cream
- Soolantra (ivermectin) 1% cream
- Ivermectin 1% cream
- Zilxi (minocycline) topical foam

### Step Therapy Requirements

#### Step 1 Drug(s):

- Metronidazole topical cream
- 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:**

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):

- dapagliflozin propanediol oral tablet
- dapagliflozin propanediol-metformin HCl ER oral tablet
- 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
- Inpefa (sotagliflozin) 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):

- dapagliflozin propanediol oral tablet
- dapagliflozin propanediol-metformin HCl ER oral tablet
- 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 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
  - 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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## 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
- 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 (Doryx generic 50mg, 75mg, 80mg, 100mg, 150mg 200mg)
- Doxycycline hyclate DR oral tablet (Targadox generic 50mg)
- 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
- Clindagel 1% gel
- Clindamycin phosphate 1% gel (clindagel generic)
- Clindamycin phosphate-benzoyl peroxide topical gel pump
- Azelex (azelaic acid) 20% topical cream
- Onexton (clindamycin phosphate-benzoyl peroxide) topical gel pump
- Veltin (clindamycin phosphate-tretinoin) topical gel
- Clindamycin phosphate-tretinoin topical gel
- Winlevi (clascoterone) topical cream
- Ziana (clindamycin phosphate-tretinoin) topical gel

### Step Therapy Requirements

#### Step 1 Drugs:

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

### 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)

- Eucrisa (crisaborole) topical ointment
- Vectical (calcitriol) ointment
- Calcitriol ointment
- Zonalon (doxepin) 5% cream
- Prudoxin (doxepin) 5% cream
- Doxepin topical cream

### Step Therapy Requirements

#### Step 1 Drug(s):

- Betamethasone dipropionate topical cream / lotion / ointment
- Betamethasone dipropionate augmented topical cream / lotion / ointment
- Betamethasone valerate topical cream / lotion / ointment
- Calcipotriene cream
- Calcipotriene ointment
- Clobetasol propionate topical cream / ointment / solution / lotion
- Desoximetasone topical cream / gel / ointment
- Fluocinonide topical cream / gel / ointment / solution
- Fluocinonide-E (fluocinonide-emollient base) topical cream
- Halobetasol propionate topical cream / 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
- Altreno (tretinoin) lotion
- Epiduo Forte (adapalene 0.3%-benzoyl peroxide 2.5%) topical gel pump
- Adapalene-benzoyl peroxide (0.3%-2.5%) topical gel pump
- Fabior (tazarotene) topical foam
- Tazarotene topical foam
- Retin-A-Micro (tretinoin microspheres) topical gel
- Tretinoin microsphere topical gel
- Retin-A-Micro Pump (tretinoin microspheres) topical gel
- Tretinoin gel micro 0.08% pump
- Tretinoin microsphere topical gel pump
- Tazorac (tazarotene) 0.05% topical cream
- Tazorac (tazarotene) topical gel
- Tazarotene topical gel
- Twyneo topical cream

### Step Therapy Requirements

#### Step 1 Drug(s):

- Adapalene 0.1%-benzoyl peroxide 2.5% topical gel pump
- Tazarotene 0.1% topical cream
- 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.



## 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>

**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
- Eletriptan hydrobromide oral tablet
- Frova (frovatriptan succinate) oral tablet
- Frovatriptan succinate oral tablet
- Migranal (dihydroergotamine mesylate) nasal spray
- Dihydroergotamine mesylate nasal spray
- Relpax (eletriptan hydrobromide) oral tablet
- Sumatriptan nasal spray
- Zolmitriptan nasal spray
- Zolmitriptan oral disintegrating tablet

#### Step 3 Drug(s):

- Trudhesa (dihydroergotamine mesylate) nasal spray
- Onzetra Xsail (sumatriptan succinate) nasal powder
- Tosymra (sumatriptan) nasal spray
- 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
- Eletriptan hydrobromide oral tablet
- Frova (frovatriptan succinate) oral tablet
- Frovatriptan succinate oral tablet
- Migranal (dihydroergotamine mesylate) nasal spray
- Dihydroergotamine mesylate nasal spray
- Relpax (eletriptan hydrobromide) oral tablet
- Sumatriptan nasal spray
- Zolmitriptan nasal spray
- Zolmitriptan oral disintegrating 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

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