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

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, 7/15/20, 3/17/21, 5/19/21, 7/21/23, 7/19/24, 7/18/25
Effective Date: 1/1/19, 5/1/21, 7/1/21, 9/15/23

Amrix® (cyclobenzaprine HCl)
Step Therapy Guidelines

Affected Medication(s)

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

Step Therapy Requirements

Step 1 Drug(s):

- Cyclobenzaprine HCl oral tablet

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)

    a. If yes, approve for 12 months
    b. If no, continue to #2

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

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

Note:

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

Last Reviewed: 10/3/18, 3/20/19, 9/15/21, 11/16/22, 11/17/23, 9/20/24, 11/21/25
Effective Date: 1/1/19, 5/1/19

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
- rivaroxaban 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

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, 9/18/19, 7/21/21, 7/20/22, 9/21/22, 9/15/23, 9/20/24, 9/19/25
Effective Date: 1/1/19, 10/15/19, 9/1/22, 11/1/22, 10/31/25

Antidepressant Agents
Step Therapy Guidelines

Affected Medication(s)

- Bupropion XL 450 mg oral tablet
- Desvenlafaxine ER oral tablet
- Desvenlafaxine fumarate ER oral tablet
- Fetzima (levomilnacipran HCl) SA oral capsule
- Forfivo XL (bupropion HCl) ER oral tablet
- Fluvoxamine ER oral capsule
- Imipramine pamoate oral capsule
- Marplan (isocarboxazid) oral tablet
- Trimipramine maleate oral capsule
- Trintellix (vortioxetine hydrobromide) 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
- Fluoxetine HCl oral capsule
- Fluvoxamine maleate oral tablet
- Paroxetine HCl oral tablet
- Sertraline HCl oral tablet
- Venlafaxine HCl oral tablet
- Duloxetine HCl oral capsule

Step Therapy Criteria

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

Note:

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

Last Reviewed: 10/3/18, 5/19/21, 7/20/2022, 9/15/23, 9/20/24, 9/19/25
Effective Date: 1/1/19, 6/15/21, 9/1/22, 11/20/23, 10/15/24

Antiglaucoma Agents
Step Therapy Guidelines

Affected Medication(s)

- Alphagan P (brimonidine tartrate) 0.1% drops
- Alphagan P (brimonidine tartrate) 0.15% eye drops
- Apraclonidine 0.5% eye drops
- Azopt (brinzolamide) ophthalmic drops
- Betimol (timolol) eye drops
- Betoptic S (betaxolol hydrochloride) 0.25% eye drops
- Bimatoprost eye drops
- Brimonidine tartrate 0.1% drops
- Brimonidine tartrate 0.15% drops
- Brinzolamide ophthalmic drops
- Iopidine 1% (apraclonidine) eye drops
- Istalol 0.5% (timolol 0.5%) eye drops
- Lumigan (bimatoprost) ophthalmic drops
- Rhopressa (netarsudil mesylate) ophthalmic drops
- Simbrinza (brinzolamide/ brimonidine tartrate) eye drop
- Timolol 0.5% eye drops (Istalol generic)
- Timolol maleate 0.25% and 0.5% eye drops (Timoptic Ocudose generic)
- Timoptic (rimolol maleate) 0.25 and 0.5% Ocudose drops
- Vyzulta (latanoprostene bunod) ophthalmic drops

Step Therapy Requirements

Step 1 Drug(s):

- Brimonidine 0.2% 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

Note:

Last Reviewed: 10/3/18, 3/20/19, 9/16/20, 11/17/21, 3/17/23, 11/20/23, 9/20/24, 11/15/24, 11/21/25
Effective Date: 1/1/19, 5/1/19, 11/15/20, 1/1/22, 6/1/23, 2/1/24, 10/15/24, 1/1/25, 1/1/26

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, 3/20/19, 9/16/20, 11/17/21, 3/17/23, 11/20/23, 9/20/24, 11/15/24, 11/21/25

Effective Date: 1/1/19, 5/1/19, 11/15/20, 1/1/22, 6/1/23, 2/1/24, 10/15/24, 1/1/25, 1/1/26

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
- Kapspargo (metoprolol) oral sprinkle
- Micardis HCT (telmisartan-hydrochlorothiazide) oral tablet
- Olmesartan-amlodipine-hydrochlorothiazide oral tablet
- Prestalia (perindopril arginine-amlodipine besylate) oral tablet
- Tekturna (aliskiren hemifumarate) 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-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

Last Reviewed: 10/3/18, 9/18/19, 9/15/21, 9/21/22, 1/20/23, 9/15/23, 9/20/24, 9/19/25
Effective Date: 1/1/19, 10/15/19, 11/1/21, 11/1/22, 3/15/23, 10/15/24

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, 9/18/19, 9/15/21, 9/21/22, 1/20/23, 9/15/2023, 9/20/24, 9/19/25
Effective Date: 1/1/19, 10/15/19, 11/1/21, 3/15/23, 10/15/24

Antiparkinson Agents
Step Therapy Guidelines

Affected Medication(s)

- Neupro transdermal patch
- Ongentys oral capsule
- Xadago oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Entacapone
- Pramipexole
- Ropinirole
- Selegiline capsule or 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 TWO Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug(s) 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: 11/18/20, 1/19/22, 1/20/23, 1/19/24, 1/17/25
Effective Date: 1/15/21, 3/15/23, 2/1/25

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

Affected Medication(s)

- Aptiom (eslicarbazepeine) oral tablet
- Eslicarbazepine oral tablet
- Xcopri (cenobamate) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Carbamazepine oral tablet
- Gabapentin oral capsule
- Gabapentin oral tablet
- Lacosamide oral tablet
- Oxcarbazepine oral tablet
- Phenobarbital oral tablet
- Phenytoin oral capsule
- Pregabalin oral capsule
- Primidone 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

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: 1/20/2021, 3/16/22, 7/21/23, 7/19/24, 9/20/24, 7/18/25
Effective Date: 3/15/2021, 9/15/23, 10/15/24, 8/1/25

Armour Thyroid
Step Therapy Guidelines

Affected Medication(s)

- Armour Thyroid oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Levothyroxine capsule
- Liothyronine tablet

Step Therapy Criteria

1. Prescription claim for TWO 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 TWO Step 1 Drug is required
    a. If yes, approve for 12 months
    b. If no, clinical review required

Note:

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

Last Reviewed:3/21/25
Effective Date: 4/1/25

Atypical Antipsychotic Agents
Step Therapy Guidelines

Affected Medication(s)

Step 2 Drug(s)

- Invega (paliperidone) ER oral tablet
- Lybalvi (olanzapine-samidorphan) oral tablet
- Paliperidone ER oral tablet
- Rexulti (brexpiprazole) oral tablet
- Saphris (asenapine maleate) sublingual tablet
- Asenapine sublingual tablet
- Vraylar (cariprazine) oral capsule

Step 3 Drug(s)

- Caplyta (lumateperone) oral capsule
- Fanapt (iloperidone) oral tablet
- Secuado (asenapine) transdermal

Step Therapy Requirements

Step 1 Drug(s)

- Olanzapine oral tablet
- Risperidone oral tablet

Step 2 Drug(s)

- Invega (paliperidone) ER oral tablet
- Lybalvi (olanzapine-samidorphan) oral tablet
- Paliperidone ER oral tablet
- Rexulti (brexpiprazole) oral tablet
- Saphris (asenapine maleate) sublingual tablet
- Asenapine sublingual tablet
- Vraylar (cariprazine) oral capsule

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)

    a. If yes 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

Last Reviewed: 10/3/18, 3/18/20, 9/16/20, 5/19/21, 11/16/22, 11/17/23, 11/15/24, 11/21/25
Effective Date: 1/1/19, 5/1/20, 11/15/20, 7/1/21, 1/1/23, 1/1/25, 1/1/26

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

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, 9/16/20, 5/19/21, 11/16/22, 11/17/23, 11/15/24, 11/21/25
Effective Date: 1/1/19, 5/1/20, 11/15/20, 7/1/21, 1/1/23, 1/1/25, 1/1/26

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.

Last Reviewed: 10/3/18, 7/21/21, 11/16/22, 11/17/23, 9/20/24, 11/21/25
Effective Date: 1/1/19

Constipation Agents
Step Therapy Guidelines

Affected Medication(s)

Step 2 Drug(s)

- Linzess (linaclotide) oral capsule
- Motegrity (prucalopride) oral tablet
- Movantik (naloxegol) oral tablet
- Prucalopride oral tablet
- Symproic (naldemedine) oral tablet

Step 3 Drug(s)

- Amitiza (lubiprostone) oral capsule
- lubiprostone oral capsule
- 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
- Motegrity (prucalopride) oral tablet
- 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

Last Reviewed: 10/3/18, 7/17/19, 5/19/21, 3/17/23, 3/15/24, 5/17/24, 1/17/25
Effective Date: 1/1/19, 9/1/19, 7/1/21, 6/15/24, 2/1/25

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

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, 7/17/19, 5/19/21, 3/17/23, 3/15/24, 5/17/24, 1/17/25
Effective Date: 1/1/19, 9/1/19, 7/1/21, 6/15/24, 2/1/25

Coreg CR® (carvedilol phosphate)
Step Therapy Guidelines

Affected Medication(s)

- Carvedilol ER (carvedilol phosphate) oral capsule
- Coreg CR (carvedilol phosphate) oral capsule

Step Therapy Requirements

Step 1 Drug(s):

- Bisoprolol oral tablet
- Carvedilol oral tablet
- Metoprolol succinate ER oral tablet
- Nebivolol 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 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, 7/21/21, 11/16/22, 11/17/23, 9/20/24, 11/21/25
Effective Date: 1/1/19, 9/1/21, 1/1/23

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-metformin HCl ER oral tablet
- Sitagliptin oral tablet
- Sitagliptin-metformin oral tablet
- Zituvimet (sitagliptin-metformin) oral tablet
- Zituvimet XR (sitagliptin-metformin) 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

Last Reviewed: 10/3/18, 3/17/21, 3/16/22, 3/17/23, 9/15/23, 1/19/24, 5/17/24, 7/19/24, 11/15/24, 11/21/25
Effective Date: 1/1/19, 5/1/21, 5/1/22, 11/20/23, 3/1/24, 6/15/24, 8/15/24, 1/1/25

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 containing 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

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, 3/17/21, 3/16/22, 3/17/23, 9/15/23, 1/19/24, 5/17/24, 7/19/24, 11/15/24, 11/21/25
Effective Date: 1/1/19, 5/1/21, 5/1/22, 11/20/23, 3/1/24, 6/15/24, 8/15/24, 1/1/25

Dry Eye Agents
Step Therapy Guidelines

Affected Medication(s)

- Tyrvaya (varenicline) Nasal Spray
- Xiidra (lifitegrast) Ophthalmic Solution

Step Therapy Requirements

Step 1 Drug(s):

- Artificial tears
- Cyclosporine Ophthalmic Solution

Step Therapy Criteria

1. Prescription claim for TWO 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 TWO Step 1 Drug is required
    a. If yes, approve for 12 months
    b. If no, clinical review required

Note:

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

Last Reviewed: 7/20/22, 5/19/23, 9/15/23, 5/17/24, 11/15/24, 9/19/25
Effective Date: 9/15/22, 7/15/23, 11/20/23, 8/1/24, 1/1/25, 10/31/25

fidaxomicin
Step Therapy Guidelines

Affected Medication(s)

- Dificid (fidaxomicin) oral tablet
- Dificid (fidaxomicin) oral suspension
- fidaxomicin oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Vancomycin HCl

Step Therapy Criteria

1. Prescription claim for ONE Step 1 Drug within the past 180 days
    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 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, 7/21/21, 11/16/22, 11/17/23, 1/19/24, 1/17/25, 3/21/25, 9/19/25
Effective Date: 1/1/19, 9/1/21, 1/1/23, 4/1/25, 10/31/25

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

Affected Medication(s)

- Advair HFA (fluticasone propionate-salmeterol xinafoate) inhalation aerosol
- Dulera (mometasone furoate-formoterol fumarate) inhalation aerosol
- Fluticasone propionate-salmeterol xinafoate inhalation aerosol

Step Therapy Requirements

Step 1 Drug(s):

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

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, 11/20/19, 9/16/20, 7/21/21, 11/16/22, 3/17/23, 3/15/24, 5/17/24, 5/16/25
Effective Date: 1/1/19, 2/1/19, 11/15/20, 1/1/23, 6/1/23, 6/15/24, 6/1/25

Inhaled Corticosteroid Agents
Step Therapy Guidelines

Affected Medication(s)

- Asmanex HFA
- Asmanex Twisthaler
- Alvesco Inhaler
- Pulmicort Flexhaler
- Qvar Redihaler

Step Therapy Requirements

Step 1 Drug(s):

- Arnuity Ellipta
- Fluticasone propionate HFA
- Fluticasone propionate diskus

Step Therapy Criteria

1. Prescription claim for ONE 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:

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: 11/15/24, 11/21/25
Effective Date: 1/1/25, 1/1/26

Insomnia Agents
Step Therapy Guidelines

Affected Medication(s)

- Dayvigo (lemborexant) oral tablet
- Doxepin oral tablet
- Edluar (zolpidem tartrate) sublingual tablet
- Silenor (doxepin HCl) oral tablet
- Zolpidem tartrate sublingual tablet
- Zolpidem tartrate oral capsule

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

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, 1/21/20, 3/18/20, 9/16/20, 1/19/22, 3/16/22, 7/21/23, 9/20/24, 9/19/25
Effective Date: 1/1/19, 5/1/20, 11/1/20, 5/1/22, 9/15/23, 10/15/24, 10/31/25

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

Affected Medication(s)

- Bevespi Aerosphere
- Duaklir Pressair

Step Therapy Requirements

Step 1 Drug(s):

- Anoro Ellipta
- Stiolto Respimat

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.

Last Reviewed: 11/15/24, 11/21/25
Effective Date: 1/1/25

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.

Last Reviewed: 10/3/18, 11/20/19, 7/21/21, 11/16/22, 3/15/24, 3/21/25
Effective Date: 1/1/19, 1/1/20, 1/1/23

Long-Acting Antimuscarinic Agents
Step Therapy Guidelines

Affected Medication(s)

- Tudorza Pressair (aclidinium bromide) inhalation powder
- Yupelri (revefenacin) solution

Step Therapy Requirements

Step 1 Drug(s):

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

Step Therapy Criteria

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

Note:

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

Last Reviewed: 10/3/18, 11/20/19, 7/21/21, 11/16/22, 3/15/24, 3/21/25
Effective Date: 1/1/19, 1/1/20, 2/1/20, 1/1/23, 6/1/24

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
- Insulin glargine 100 unit/mL subcutaneous vial

Step Therapy Requirements

Step 1 Drug(s):

- Insulin glargine-yfgn subcutaneous vial
- Insulin glargine-yfgn subcutaneous pen
- Rezvoglar subcutaneous kwikpen
- Lantus subcutaneous vial
- Lantus Solostar 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.

Last Reviewed: 10/3/18, 3/17/21, 11/16/22, 5/19/23, 3/15/24, 7/19/24, 3/21/25
Effective Date: 1/1/19, 5/1/21, 2/1/23, 7/15/23, 9/1/23, 4/15/24, 8/15/24, 4/1/25

Long-Acting Opioid Agents
Step Therapy Guidelines

riAffected 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

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(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.

Last Reviewed: 10/3/18, 9/18/19, 9/15/21, 3/16/22, 5/19/23, 5/17/24, 5/16/25
Effective Date: 1/1/19, 10/15/19, 5/1/22, 8/1/24

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.

Last Reviewed: 10/3/18, 5/20/20, 3/17/21, 3/16/22, 11/16/22, 11/17/23, 9/20/24, 11/21/25
Effective Date: 1/1/19, 7/1/20, 5/1/22, 1/1/23

NSAID Agents
Step Therapy Guidelines

Affected Medication(s)

- Daypro oral tablet
- Ketoprofen oral capsule
- Ketoprofen ER oral capsule
- Kiprofen 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 oral 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.

Last Reviewed: 10/3/18, 9/16/20, 1/19/22, 1/20/23, 1/19/24, 5/17/24, 5/16/25
Effective Date: 1/1/19, 11/15/20, 3/1/22, 3/15/23, 8/1/24

Overactive Bladder Agents
Step Therapy Guidelines

Affected Medication(s)

- Darifenacin ER oral tablet
- fesoterodine fumarate ER oral tablet
- Gemtesa (vibegron) oral tablet
- Mirabegron ER 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.

Last Reviewed: 10/3/18, 3/17/21, 9/15/21, 3/16/22, 7/20/22, 1/20/23, 1/19/24, 5/17/24, 9/20/24, 9/19/25
Effective Date: 1/1/19, 5/1/21, 11/1/21, 5/1/22, 9/1/22, 3/15/23, 6/15/24, 10/15/24

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

Last Reviewed: 7/17/19, 7/21/21, 7/20/22, 7/21/23, 7/19/24, 7/18/25
Effective Date: 9/1/19

PCSK9 Inhibitor Agents
Step Therapy Guidelines

Affected Medication(s)

- Praluent subcutaneous solution
- Repatha subcutaneous solution

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 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.

Last Reviewed: 11/15/24, 11/21/25
Effective Date: 1/1/25

Proton Pump Inhibitor Agents
Step Therapy Guidelines

Affected Medication(s)

- Aciphex Sprinkle (rabeprazole sodium) DR oral capsule
- rabeprazole sprinkle DR oral capsule
- Dexilant (dexlansoprazole) DR oral capsule
- dexlansoprazole DR oral capsule
- Nexium (esomeprazole magnesium) DR oral suspension packet
- esomeprazole DR oral suspension packet
- esomeprazole magnesium suspension packet
- Prevacid (lansoprazole) DR Solutab
- 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:

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, 5/20/20, 9/16/20, 1/19/22, 3/17/23, 1/19/24, 1/17/25, 3/21/25
Effective Date: 1/1/19, 7/1/20. 11/15/20, 3/1/22, 3/1/24, 4/1/25

Pregabalin CR
Step Therapy Guidelines

Affected Medication(s)

- Lyrica CR (pregabalin) oral tablet
- Pregabalin CR tablet

Step Therapy Requirements

Step 1 Drug(s):

- Duloxetine HCl DR oral capsule
- Gabapentin oral capsule
- Gabapentin oral solution
- Gabapentin 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.

Last Reviewed: 10/3/18, 11/20/19, 5/19/21, 5/18/22, 7/21/23, 7/19/24, 7/18/25
Effective Date: 1/1/19, 1/1/20, 7/1/21, 8/1/25

Rosacea Agents
Step Therapy Guidelines

Affected Medication(s)

- Epsolay (benzoyl peroxide) 5% cream pump
- Finacea (azelacid acid) 15% foam
- Metrolotion (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.

Last Reviewed: 10/3/18, 7/15/20, 9/16/20, 1/19/22, 7/20/22, 5/19/23, 7/21/23, 7/19/24, 7/18/25
Effective Date: 1/1/19, 08/15/20, 11/15/20, 3/1/22, 9/1/22, 9/15/23

Sodium-Glucose Cotransporter-2 Inhibitors
Step Therapy Guidelines

Affected Medication(s)

Step 2 Drugs:

- Bexagliflozin oral tablet
- Brenzavvy (bexagliflozin) oral tablet
- Dapagliflozin propanediol oral tablet
- Dapagliflozin propanediol-metformin HCl ER oral tablet
- 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 Drugs:

- Farxiga (dapagliflozin propanediol) oral tablet
- Jardiance (empagliflozin) oral tablet
- Synjardy (empagliflozin-metformin HCl) oral tablet
- Synjardy XR (empagliflozin-metformin HCl) oral tablet
- Xigduo XR (dapagliflozin propanediol-metformin HCl) oral tablet
- Trijardy XR (empagliflozin-linagliptin-metformin) oral tablet

Step Therapy Criteria

1. 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, approve for 12 months
    b. If no, continue to #2
2. Does the member have documentation of trial, intolerance or contraindication to TWO Step 1 Drug(s)?
    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, 3/17/21, 1/19/22, 3/17/23, 7/21/23, 3/15/24, 1/17/25, 3/21/25
Effective Date: 1/1/19, 5/1/21, 3/1/22, 6/1/23, 9/15/23, 4/15/24, 4/1/25

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:

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, 9/16/20, 1/19/22, 7/15/22, 7/21/23, 1/19/24, 1/17/25
Effective Date: 1/1/19, 11/15/20, 9/1/22, 3/1/24

Tetracycline Antibiotic Agents
Step Therapy Guidelines

Affected Medication(s)

- Acticlate oral tablet
- Doryx (doxycycline hyclate) DR oral tablet
- Doryx MPC (doxycycline hyclate) DR oral tablet
- Doxycycline 50mg oral tablet
- Doxycycline hyclate DR oral tablet (Doryx generic 50mg, 75mg, 80mg, 100mg, 150mg, 200mg)
- Doxycycline hyclate DR oral tablet (Targadox generic 50mg)
- Doxycycline hyclate 75 mg & 150 mg oral tablet (Acticlate generic)
- Doxycycline IR-DR oral capsule
- Emrosi (minocycline) ER oral capsule
- Coremino ER (minocycline ER) oral tablet
- Minocycline HCl ER oral capsule
- Minocycline ER oral tablets
- Minolira ER (minocycline ER) oral tablet
- 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 50 mg, 75 mg, & 100 mg oral tablet
- Doxycycline monohydrate 50 mg & 100 mg oral capsule
- 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.

Last Reviewed: 10/3/18, 5/20/20, 9/15/21, 11/16/22, 11/17/23, 9/20/24, 11/15/24, 1/17/25
Effective Date: 1/1/19, 5/20/20, 11/15/21, 2/1/24, 1/1/25, 2/1/25

Topical Acne Agents
Step Therapy Guidelines

Affected Medication(s)

- Clindagel 1% gel
- Clindamycin phosphate 1% gel (clindagel generic)
- Clindamycin phosphate-benzoyl peroxide 1.2-3.75% topical gel pump
- Azelex (azelaic acid) 20% topical cream
- Onexton (clindamycin phosphate-benzoyl peroxide) 1.2-3.75% 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) 1.2-5% topical gel
- Clindamycin phosphate-benzoyl peroxide 1.2-5% topical gel (Neuac generic)
- Clindamycin phosphate-benzoyl peroxide 1-5% topical gel
- Clindamycin phosphate-benzoyl peroxide 1-5% 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.

Last Reviewed: 10/3/18, 7/15/20, 5/19/21, 7/21/23, 11/20/23, 5/17/24, 7/19/24, 7/18/25
Effective Date: 1/1/19, 8/15/20, 7/1/21, 9/15/23, 2/1/24, 8/15/24, 8/1/25

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.

Last Reviewed: 10/3/18, 7/15/20, 7/21/23, 7/19/24, 7/18/25
Effective Date: 1/1/19, 9/15/20, 9/15/23

Topical Vitamin A Derivatives
Step Therapy Guidelines

Affected Medication(s)

- Aklief (trifarotene) topical cream
- Altreno (tretinoin) lotion
- Arazlo (tazarotene) topical lotion
- Fabior (tazarotene) topical foam
- Retin-A-Micro (tretinoin microspheres) topical gel
- Retin-A-Micro Pump (tretinoin microspheres) topical gel
- Tazarotene 0.05% topical cream
- Tazarotene topical foam
- Tazarotene topical gel
- Tazorac (tazarotene) 0.05% topical cream
- Tazorac (tazarotene) topical gel
- Tretinoin gel micro 0.08% pump
- Tretinoin microsphere topical gel
- Tretinoin microsphere topical gel pump
- Twyneo (tretinoin 0.1%-benzoyl peroxide 3%) topical cream

Step Therapy Requirements

Step 1 Drug(s):

- 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.

Last Reviewed: 10/3/18, 3/18/20, 7/15/20, 11/18/20, 5/19/21, 7/21/21, 1/19/22, 5/19/23, 7/21/23, 11/17/23, 7/19/24, 11/15/24, 7/18/25
Effective Date: 1/1/19, 5/1/20, 8/15/20, 12/15/20, 7/1/21, 9/1/21, 3/1/22, 9/15/23, 12/20/23, 8/15/24, 1/1/25, 8/1/25

Tramadol
Step Therapy Guidelines

Affected Medication(s)

- ConZip (tramadol HCl) oral capsule
- Tramadol ER capsule

Step Therapy Requirements

Step 1 Drug(s):

- Tramadol HCl oral tablet
- Tramadol HCl ER 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 Drug is required
    a. If yes, approve for 12 months
    b. If no, clinical review required

Note:

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

Last Reviewed: 10/3/18, 9/18/19, 9/15/21, 11/16/22, 11/17/23, 9/20/24, 11/21/25
Effective Date: 1/1/19, 10/15/19, 11/15/21

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

Last Reviewed: 10/3/18, 11/20/19, 11/18/20, 1/19/22. 3/16/22, 5/19/23, 5/17/24, 7/18/25
Effective Date: 1/1/19, 12/15/20, 3/1/22, 5/1/22, 7/15/23

2. Does the member have prescription claim for TWO Step 1 Drug(s) within the past 180 days? (Note: 30 days of claims history required for authorization)
    a. If yes, approve Step 2 Drug for 12 months
    b. If no, continue to #3
3. Does the member have documentation of trial, intolerance or contraindication to TWO Step 1 Drug?
    a. If yes, approve Step 2 Drug for 12 months.
    b. If no, clinical review required
4. Does the member have prescription claim for TWO Step 1 Drug(s) within the past 180 days? (Note: 90 days of claims history required for authorization)
    a. If yes, continue to #6
    b. If no, continue to #5
5. Does the member have documentation of trial, intolerance or contraindication to TWO Step 1 Drug?
    a. If yes, continue to #6
    b. If no, clinical review required
6. Does the member have prescription claim(s) for ONE Step 2 Drug(s) within the past 180 days? (Note: 30 days of claims history required for authorization)
    a. If yes, approve step 3 drug for 12 months
    b. If no, continue to #7
7. Does the member have documentation of trial, intolerance, or contraindication to ONE Step 2 Drug?
    a. If yes, approve step 3 drug for 12 months
    b. If no, clinical review is required

Note:

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

Last Reviewed: 10/3/18, 11/20/19, 11/18/20, 1/19/22, 3/16/22, 5/19/23, 5/17/24, 7/18/25
Effective Date: 1/1/19, 12/15/20, 3/1/22, 5/1/22, 7/15/23