2025 STEP THERAPY CRITERIA

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Step Therapy Group:
Oral Inhalers ST - Advair Diskus
Drug Name(s)
Advair Diskus
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Oral Inhalers ST - Spiriva Handihaler
Drug Name(s)
Spiriva Handihaler
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Oral Inhalers ST – Symbicort
Drug Name(s)
Symbicort
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
PPI ST – Aciphex
Drug Name(s)
Aciphex
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
PPI ST – Nexium
Drug Name(s)
Nexium
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
PPI ST – Prevacid
Drug Name(s)
Prevacid
Prevacid Solutab
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
PPI ST – Protonix
Drug Name(s)
Protonix
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Statins ST – Crestor
Drug Name(s)
Crestor
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Statins ST - Lescol XL
Drug Name(s)
Lescol XL
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Statins ST – Lipitor
Drug Name(s)
Lipitor
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Statins ST – Vytorin
Drug Name(s)
Vytorin
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Statins ST – Zocor
Drug Name(s)
Zocor
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Triptans ST – Frova
Drug Name(s)
Frova
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Triptans ST - Imitrex injectable
Drug Name(s)
Imitrex Statdose System
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Triptans ST - Imitrex tablet
Drug Name(s)
Imitrex Tablet
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Triptans ST – Maxalt
Drug Name(s)
Maxalt
Maxalt-MLT
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Triptans ST – Relpax
Drug Name(s)
Relpax
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Triptans ST – Treximet
Drug Name(s)
Treximet
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Urinary Incontinence ST - Detrol
Drug Name(s)
Detrol
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Urinary Incontinence ST - Detrol LA
Drug Name(s)
Detrol LA
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Urinary Incontinence ST - Toviaz
Drug Name(s)
Toviaz
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:
Urinary Incontinence ST – Vesicare
Drug Name(s)
Vesicare
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

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