2023 STEP THERAPY CRITERIA

TABLE OF CONTENTS

Step Therapy Group:
Febuxostat ST
Drug Name(s)
Febuxostat
Uloric
Criteria:
Criteria for approval require the following:
1. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient's medication history includes use of generic allopurinol within the past 90 days OR
    D. Patient has an intolerance or hypersensitivity to generic allopurinol OR
    E. Patient had an ineffective treatment response to generic allopurinol OR
    F. Patient has an FDA labeled contraindication to generic allopurinol

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

Step Therapy Group:
Fluticasone-Salmeterol ST
Drug Name(s)
Fluticasone Propionate/Salmeterol
Fluticasone Propionate/Salmeterol Diskus
Wixela Inhub
Criteria:
Criteria for approval require ONE of the following:
1. Patient's medication history includes use of Advair Diskus within the past 90 days OR
2. Patient has an intolerance or hypersensitivity to Advair Diskus OR
3. Patient had an ineffective treatment response to Advair Diskus OR
4. Patient has an FDA labeled contraindication to Advair Diskus

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

Step Therapy Group:
GLP-1 Agonists ST
Drug Name(s)
Adlyxin
Adlyxin Starter Pack
Bydureon Bcise
Bydureon Pen
Byetta
Mounjaro
Ozempic
Rybelsus
Trulicity
Victoza
Criteria:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient's medication history includes use of metformin or an agent containing metformin within the past 90 days OR
    D. Patient has an intolerance or hypersensitivity to metformin or an agent containing metformin OR
    E. Patient had an ineffective treatment response to metformin or an agent containing metformin OR
    F. Patient has an FDA labeled contraindication to metformin or an agent containing metformin

For Ozempic, Trulicity, and Victoza: NO prerequisites are required for diagnosis of type 2 diabetes mellitus and multiple cardiovascular risk factors or established cardiovascular disease.

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

Approval authorizations will apply to the requested medication only.

Step Therapy Group:
Insulin ST – Combinations
Drug Name(s)
Insulin Aspart Protamine/Insulin Aspart
Insulin Aspart Protamine/Insulin Aspart Flexpen
Insulin Lispro Protamine/Insulin Lispro Kwikpen
Novolin 70/30
Novolin 70/30 Flexpen Relion
Novolin 70/30 Relion
Novolog Mix 70/30
Novolog Mix 70/30 Prefilled Flexpen
Criteria:
Criteria for approval require the following:
1. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient's medication history includes use of a preferred Mix insulin (Humalog Mix or Humulin 70/30) within the past 90 days OR
    D. Patient has an intolerance or hypersensitivity to a preferred Mix insulin (Humalog Mix or Humulin 70/30) OR
    E. Patient had an ineffective treatment response to a preferred Mix insulin (Humalog Mix or Humulin 70/30) OR
    F. Patient has an FDA labeled contraindication to a preferred Mix insulin (Humalog Mix or Humulin 70/30)

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

Approval authorizations will apply to the requested medication only.

Step Therapy Group:
Insulin ST - Intermediate Acting
Drug Name(s)
Novolin N
Novolin N Flexpen
Novolin N Flexpen Relion
Novolin N Relion
Criteria:
Criteria for approval require the following:
1. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient's medication history includes use of a preferred NPH insulin (Humulin N) within the past 90 days OR
    D. Patient has an intolerance or hypersensitivity to a preferred NPH insulin (Humulin N) OR
    E. Patient had an ineffective treatment response to a preferred NPH insulin (Humulin N) OR
    F. Patient has an FDA labeled contraindication to a preferred NPH insulin (Humulin N)

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

Approval authorizations will apply to the requested medication only.

Step Therapy Group:
Insulin ST - Rapid Acting
Drug Name(s)
Admelog
Admelog Solostar
Apidra
Apidra Solostar
Fiasp
Fiasp Flextouch
Fiasp Penfill
Insulin Aspart
Insulin Aspart Flexpen
Insulin Aspart Penfill
Insulin Lispro
Insulin Lispro Junior Kwikpen
Insulin Lispro Kwikpen
Novolog
Novolog Flexpen
Novolog Flexpen Relion
Novolog Penfill
Novolog Relion
Criteria:
Criteria for approval require the following:
1. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient's medication history includes use of a preferred rapid insulin (Humalog or Lyumjev) within the past 90 days OR
    D. Patient has an intolerance or hypersensitivity to a preferred rapid insulin (Humalog or Lyumjev) OR
    E. Patient had an ineffective treatment response to a preferred rapid insulin (Humalog or Lyumjev) OR
    F. Patient has an FDA labeled contraindication to a preferred rapid insulin (Humalog or Lyumjev)

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

Approval authorizations will apply to the requested medication only.

Step Therapy Group:
Insulin ST - Short Acting
Drug Name(s)
Novolin R
Novolin R Flexpen
Novolin R Flexpen Relion
Novolin R Relion
Criteria:
Criteria for approval require the following:
1. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient's medication history includes use of a preferred regular insulin (Humulin R) within the past 90 days OR
    D. Patient has an intolerance or hypersensitivity to a preferred regular insulin (Humulin R) OR
    E. Patient had an ineffective treatment response to a preferred regular insulin (Humulin R) OR
    F. Patient has an FDA labeled contraindication to a preferred regular insulin (Humulin R)

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

Approval authorizations will apply to the requested medication only.

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:
PPI ST – Zegerid
Drug Name(s)
Zegerid
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 Injectable
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 nasal spray
Drug Name(s)
Imitrex Nasal Spray
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:
Triptans ST – Zomig
Drug Name(s)
Zomig
Zomig ZMT
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 – 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

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