



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.



Amrix® (cyclobenzaprine HCl) Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">Amrix (cyclobenzaprine HCl) ER oral capsuleCyclobenzaprine ER oral capsule	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">Cyclobenzaprine HCl oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, clinical review required	

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Anticoagulant Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">dabigatran oral capsulePradaxa (dabigatran etexilate mesylate) oral capsuleSavaysa (edoxaban tosylate) oral tablet	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">Eliquis (apixaban) oral tabletXarelto (rivaroxaban) oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, clinical review required	

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Antidepressant Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Desvenlafaxine ER oral tablet• Desvenlafaxine fumarate ER oral tablet• Fetzima (levomilnacipran HCl) SA oral capsule• Forfiv XL (bupropion HCl) ER oral tablet• Marplan (isocarboxazid) oral tablet• Trimipramine maleate oral capsule• Trintellix (vortioxetine hydrobromide) oral tablet• Viibryd (vilazodone HCl) oral tablet• vilazodone oral tablet
Step Therapy Requirements
<p>Step 1 Drug(s):</p> <ul style="list-style-type: none">• Citalopram hydrobromide oral tablet• Desvenlafaxine succinate ER oral tablet• Escitalopram oxalate oral tablet• Fluoxetine HCl oral tablet• Fluvoxamine maleate oral tablet• Paroxetine HCl oral tablet• Sertraline HCl oral tablet• Venlafaxine HCl oral tablet• Duloxetine HCl oral capsule
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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Antiglaucoma Agents Step Therapy Guidelines

Affected Medication(s)

- Alphagan P 0.1% drops
- Alphagan P 0.15% eye drops
- Apraclonidine 0.5% eye drops
- Azopt (brinzolamide) ophthalmic drops
- Betimol eye drops
- Betoptic S 0.25% eye drops
- Bimatoprost eye drops
- Brimonidine tartrate 0.1% drops
- Brimonidine tartrate 0.15% drops
- Brimonidine-timolol 0.2%-0.5%
- Brinzolamide ophthalmic drops
- Combigan 0.2%-0.5% eye drops
- Iopidine 1% eye drops
- Istalol 0.5% (timolol 0.5%) eye drops
- Lumigan (bimatoprost) ophthalmic drops
- Rhopressa (netarsudil mesylate) ophthalmic drops
- Simbrinza eye drop
- Tafluprost ophthalmic dropperette
- Timolol maleate 0.25% and 0.5% eye drops (Timoptic Ocudose generic)
- Timoptic 0.25 and 0.5% Ocudose drops
- Travatan Z 0.004% (travoprost) ophthalmic drops
- Travoprost ophthalmic drops
- Vyzulta (latanoprostene bunod) ophthalmic drops
- Xelpros (latanoprost) ophthalmic emulsion
- Zioptan (tafluprost) ophthalmic dropperette

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:

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

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



Antihypertensive Agents Step Therapy Guidelines

Affected Medication(s)

- Aliskiren hemifumarate
- Amlodipine besylate-valsartan-hydrochlorothiazide oral tablet
- Atacand (candesartan cilexetil) oral tablet
- Atacand HCT (candesartan cilexetil-hydrochlorothiazide) oral tablet
- Candesartan cilexetil oral tablet
- Candesartan cilexetil-hydrochlorothiazide oral tablet
- Captopril-hydrochlorothiazide oral tablet
- Edarbi (azilsartan medoxomil) oral tablet
- Edarbyclor (azilsartan medoxomil-chlorthalidone) oral tablet
- Exforge HCT (amlodipine besylate-valsartan-hydrochlorothiazide) oral tablet
- Kaspargo (metoprolol) oral sprinkle
- Micardis HCT (telmisartan-hydrochlorothiazide) oral tablet
- Nadolol-bendroflumethiazide
- Olmesartan-amlodipine-hydrochlorothiazide oral tablet
- Prestalia (perindopril arginine-amlodipine besylate) oral tablet
- Tekturna (aliskiren hemifumarate) oral tablet
- Tekturna HCT (aliskiren hemifumarate-hydrochlorothiazide) oral tablet
- Telmisartan-amlodipine besylate oral tablet
- Telmisartan-hydrochlorothiazide oral tablet
- Trandolapril-verapamil oral tablet
- Tribenzor (olmesartan medoxomil-amlodipine besylate-hydrochlorothiazide) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Bisoprolol-hydrochlorothiazide oral tablet
- Irbesartan oral tablet
- Irbesartan-hydrochlorothiazide oral tablet
- Losartan potassium oral tablet
- Losartan-hydrochlorothiazide oral tablet
- Olmesartan medoxomil oral tablet
- Olmesartan-hydrochlorothiazide
- Valsartan oral tablet
- Valsartan-hydrochlorothiazide oral tablet

Step Therapy Criteria

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



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

Note:

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Antiparkinson Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Neupro transdermal patch• Ongentys oral capsule• Xadago oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Entacapone• Pramipexole• Ropinirole• Selegiline capsule or tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of TWO Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug(s) is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



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

Affected Medication(s)	
<ul style="list-style-type: none">• Aptiom (eslicarbazepeine) oral tablet• Xcopri (cenobamate) oral tablet	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• 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	
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drugs are required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



Atypical Antipsychotic Agents Step Therapy Guidelines

Affected Medication(s)	
Step 2 Drug(s) <ul style="list-style-type: none">• Invega (paliperidone) ER 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) <ul style="list-style-type: none">• Caplyta (lumateperone) oral capsule• Fanapt (iloperidone) oral tablet• Secuado (asenapine) transdermal	
Step Therapy Requirements	
Step 1 Drug(s) <ul style="list-style-type: none">• Aripiprazole oral tablet• Olanzapine oral tablet• Quetiapine fumarate oral tablet• Risperidone oral tablet Step 2 Drug(s) <ul style="list-style-type: none">• Invega (paliperidone) ER 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	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes for Step 2 drug, approve for 12 monthsb. If yes for Step 3 drug, continue to #3c. If no for Step 2 or Step 3 drug, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes for Step 2 drug, approve for 12 monthsb. If yes for Step 3 drug, continue to #3c. If no for Step 2 or Step 3 drug, clinical review required	



3. Prescription claim for ONE Step 2 Drug(s) within the past 180 days (Note: 90 days of claim history required for authorization)
 - a. If yes, approve for 12 months
 - b. If no, continue to #4
4. If no claim history of Step 2 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 2 Drugs required.
 - a. If yes, approve for 12 months
 - b. If no, clinical review required

Note:

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Bisphosphonate Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">Actonel (risedronate sodium) oral tabletAtelvia (risedronate sodium) DR oral tabletBinosto (alendronate sodium) effervescent tabletFosamax Plus D (alendronate sodium-cholecalciferol) oral tabletRisedronate sodium DR oral tabletRisedronate sodium oral tablet	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">Alendronate sodium oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, clinical review required	

Note:

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



Constipation Agents Step Therapy Guidelines

Affected Medication(s)	
Step 2 Drug(s) <ul style="list-style-type: none">• Linzess (linaclotide) oral capsule• Motegrity (prucalopride) oral tablet• Movantik (naloxegol) oral tablet• Prucalopride oral tablet• Symproic (naldemedine) oral tablet Step 3 Drug(s) <ul style="list-style-type: none">• Amitiza (lubiprostone) oral capsule• lubiprostone oral capsule• Trulance (plecanatide) oral tablet	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• polyethylene glycol 3350 powder• lactulose solution Step 2 Drug(s) <ul style="list-style-type: none">• Linzess (linaclotide) oral capsule• Motegrity (prucalopride) oral tablet• Movantik (naloxegol) oral tablet• Symproic (naldemedine) oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes for Step 2 drug, approve for 12 monthsb. If yes for Step 3 drug, continue to #3c. If no for Step 2 or Step 3 drug, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes for Step 2 drug, approve for 12 monthsb. If yes for Step 3 drug, continue to #3c. If no for Step 2 or Step 3 drug, clinical review required3. Prescription claim for ONE Step 2 Drug(s) within the past 180 days (Note: 90 days of claim history required for authorization)<ol style="list-style-type: none">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:

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Coreg CR® (carvedilol phosphate) Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Carvedilol ER (carvedilol phosphate) oral capsule• Coreg CR (carvedilol phosphate) oral capsule	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Bisoprolol oral tablet• Carvedilol oral tablet• Metoprolol succinate ER oral tablet• Nebivolol oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	

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Dificid® (fidaxomicin) Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Dificid oral tablet• Dificid oral suspension	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Vancomycin HCl	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug, documentation of trial, intolerance or contraindication to ONE Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	

Note:

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Dipeptidyl Peptidase-4 Enzyme Inhibitor Agents Step Therapy Guidelines

Affected Medication(s)
<p>Step 2 Drug(s):</p> <ul style="list-style-type: none">• 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 <p>Step 3 Drug(s)</p> <ul style="list-style-type: none">• 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
<p>Step 1 Drug(s):</p> <ul style="list-style-type: none">• Metformin HCl oral tablet• Metformin HCl ER oral tablet <p>Step 2 Drug(s):</p> <ul style="list-style-type: none">• Januvia (sitagliptin phosphate) oral tablet• Janumet (sitagliptin phosphate-metformin HCl) oral tablet• Janumet XR (sitagliptin phosphate-metformin HCl) oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Is the request for a Step 2 medication?<ol style="list-style-type: none">a. If yes continue to #2b. 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

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Dry Eye Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Cequa Ophthalmic Solution• Restasis MultiDose Emulsion• Verkazia Ophthalmic Emulsion• Vevye Ophthalmic Solution• Xiidra Ophthalmic Solution	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Cyclosporine Ophthalmic Solution	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug, documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	

Note:

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

Affected Medication(s)
<ul style="list-style-type: none">• Advair HFA (fluticasone propionate-salmeterol xinafoate) inhalation aerosol• AirDuo DigiHaler (fluticasone propionate-salmeterol xinafoate) inhalation powder• Dulera (mometasone furoate-formoterol fumarate) inhalation powder• Fluticasone propionate-salmeterol xinafoate inhalation aerosol
Step Therapy Requirements
<p>Step 1 Drug(s):</p> <ul style="list-style-type: none">• AirDuo RespiClick (fluticasone propionate-salmeterol) inhalation powder• Fluticasone propionate-salmeterol inhaler• Breo Ellipta (fluticasone furoate-vilanterol) inhalation powder• Fluticasone furoate-vilanterol inhaler• Symbicort (budesonide-formoterol fumarate) inhalation powder• Breyna (budesonide-formoterol fumarate) inhalation powder• Budesonide-formoterol fumarate inhaler
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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Inhaled Corticosteroid Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Asmanex HFA• Asmanex Twisthaler• Alvesco Inhaler• Armonair Digihaler• Pulmicort Flexhaler• Qvar Redihaler
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Arnuity Ellipta• Fluticasone propionate HFA• Fluticasone propionate diskus
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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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 (Intermezzo)
- 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:

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

Affected Medication(s)
<ul style="list-style-type: none">• Bevespi Aerosphere• Duaklir Pressair
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Anoro Ellipta• Stiolto Respimat
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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



Long-Acting Beta Agonist Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Brovana (arformoterol tartrate) inhalation solution• arformoterol tartrate inhalation solution• Perforomist (formoterol fumarate) inhalation solution• formoterol fumarate inhalation solution	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Serevent Diskus (salmeterol xinafoate) inhalation powder• Striverdi Respimat (olodaterol) inhaler spray	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug, documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	

Note:

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



Long-Acting Antimuscarinic Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">Tudorza Pressair (aclidinium bromide) inhalation powderYupelri (revefenacin) solution	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">Incruse Ellipta (umeclidinium bromide) inhalation powderSpiriva (tiotropium bromide) Handihaler/Respimattiotropium bromide inhalation powder capsules	
Step Therapy Criteria	
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, clinical review required	

Note:

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Long-Acting Insulin Agents Step Therapy Guidelines

Affected Medication(s)

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

Step Therapy Requirements

Step 1 Drug(s):

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



Long-Acting Opioid Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">Hydromorphone ER oral tabletNucynta EROxymorphone ER oral tabletOxycontin (oxycodone HCl) oral tabletXtampza ER (oxycodone myristate) oral capsule	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">Fentanyl transdermal patchMorphine sulfate ER oral tabletMorphine sulfate ER oral capsule	
Step Therapy Criteria	
<ol style="list-style-type: none">Prescription claim for ONE Step 1 Drug within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, clinical review required	

Note:

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



Lyrica® CR (pregabalin) Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Lyrica CR (pregabalin) oral tablet• Pregabalin CR tablet	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Duloxetine HCl DR oral capsule• Gabapentin oral capsule• Gabapentin oral solution• Gabapentin oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



Nasal Steroid Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Dymista (azelastine HCl-fluticasone propionate) nasal spray• Azelastine-fluticasone nasal spray• Ryaltris (olopatadine-mometasone) spray	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Flunisolide nasal spray• Fluticasone propionate nasal spray• Olopatadine nasal spray	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	

Note:

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



NSAID Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• 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
<p>Step 1 Drug(s):</p> <ul style="list-style-type: none">• 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
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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Overactive Bladder Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• 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): <ul style="list-style-type: none">• Oxybutynin chloride oral tablet• Oxybutynin chloride ER oral tablet• Tolterodine tartrate oral tablet• Trospium chloride oral tablet• Solifenacin succinate oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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



Pancreatic Enzymes Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Pancreaze (lipase/protease/amylase) capsule• Pertzye (lipase/protease/amylase) capsule• Viokace (lipase/protease/amylase) capsule	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Creon (lipase/protease/amylase) capsule• Zenpep (lipase/protease/amylase) capsule	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	



PCSK9 Inhibitor Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Praluent subcutaneous solution• Repatha subcutaneous solution	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Atorvastatin calcium oral tablet• Lovastatin oral tablet• Pravastatin sodium oral tablet• Rosuvastatin calcium oral tablet• Simvastatin oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	

Note:

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Proton Pump Inhibitor Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• 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• 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
<p>Step 1 Drug(s):</p> <ul style="list-style-type: none">• esomeprazole DR oral capsule• lansoprazole DR oral capsule• omeprazole DR oral capsule• pantoprazole sodium DR oral tablet• rabeprazole DR oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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Rosacea Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Epsolay (benzoyl peroxide) 5% cream pump• Finacea (azelaic 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): <ul style="list-style-type: none">• Metronidazole topical cream• Metronidazole topical gel pump• Metronidazole topical gel• Azelaic acid gel
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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



Sodium-Glucose Cotransporter-2 Inhibitors Step Therapy Guidelines

Affected Medication(s)
Step 2 Drugs: <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• 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
<ol style="list-style-type: none">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)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. Does the member have documentation of trial, intolerance or contraindication to TWO Step 1 Drug(s)?<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review requiredc.

Note:

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Statin Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">Ezallor Sprinkle (rosuvastatin) oral capsuleFluvastatin sodium ER oral tabletFluvastatin sodium oral capsuleLescol (fluvastatin) oral capsuleLescol XL (fluvastatin) oral tabletLivalo (pitavastatin calcium) oral tabletPitavastatin calcium oral tabletZypitamag (pitavastatin magnesium) oral tablet
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">Atorvastatin calcium oral tabletLovastatin oral tabletPravastatin sodium oral tabletRosuvastatin calcium oral tabletSimvastatin oral tablet
Step Therapy Criteria
<ol style="list-style-type: none">Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, continue to #2If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">If yes, approve for 12 monthsIf no, clinical review required

Note:

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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.



Topical Acne Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Acanya (clindamycin phosphate-benzoyl peroxide) 1.2-2.5% topical gel pump• Clindagel 1% gel• Clindamycin phosphate 1% gel (clindagel generic)• Clindamycin phosphate-benzoyl peroxide 1.2-2.5% topical gel pump• 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
<p>Step 1 Drugs:</p> <ul style="list-style-type: none">• 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• Clindamycin phosphate-benzoyl peroxide 1-5% topical gel• Clindamycin phosphate-benzoyl peroxide 1-5% topical gel pump
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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



Topical Antibiotic Agents Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• Altabax 1% ointment• Xepi 1% cream	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Mupirocin 2% cream• Mupirocin 2% ointment	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for ONE Step 1 Drug within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug, documentation of trial, intolerance or contraindication to ONE Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required	

Note:

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



Topical Anti-Inflammatory Agents Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Eucrisa (crisaborole) topical ointment• Vectical (calcitriol) ointment• Calcitriol ointment• Zonalon (doxepin) 5% cream• Prudoxin (doxepin) 5% cream• Doxepin topical cream
Step Therapy Requirements
<p>Step 1 Drug(s):</p> <ul style="list-style-type: none">• 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
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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



Topical Vitamin A Derivatives Step Therapy Guidelines

Affected Medication(s)
<ul style="list-style-type: none">• Adapalene 0.3% gel pump• Adapalene-benzoyl peroxide (0.3%-2.5%) topical gel pump• Akliel (trifarotene) topical cream• Altreno (tretinoin) lotion• Arazlo (tazarotene) topical lotion• Epiduo Forte (adapalene 0.3%-benzoyl peroxide 2.5%) topical gel pump• Fabior (tazarotene) topical foam• Retin-A-Micro (tretinoin microspheres) topical gel• Retin-A-Micro Pump (tretinoin microspheres) topical gel• 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• Twynéo topical cream
Step Therapy Requirements
Step 1 Drug(s): <ul style="list-style-type: none">• Adapalene 0.1%-benzoyl peroxide 2.5% topical gel pump• Tazarotene 0.1% topical cream• Tretinoin topical cream• Tretinoin topical gel
Step Therapy Criteria
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 Drugs is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, clinical review required

Note:

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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

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Tramadol Step Therapy Guidelines

Affected Medication(s)	
<ul style="list-style-type: none">• ConZip (tramadol HCl) oral capsule• Tramadol ER capsule	
Step Therapy Requirements	
Step 1 Drug(s): <ul style="list-style-type: none">• Tramadol HCl oral tablet• Tramadol HCl ER oral tablet	
Step Therapy Criteria	
<ol style="list-style-type: none">1. Prescription claim for TWO Step 1 Drugs within the past 180 days (Note: 90 days of claims history required for authorization)<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. If no, continue to #22. If no claim history of Step 1 Drugs, documentation of trial, intolerance or contraindication to TWO Step 1 Drug is required<ol style="list-style-type: none">a. If yes, approve for 12 monthsb. 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.



Triptan Agents Step Therapy Guidelines

Affected Medication(s)

Step 2 Drug(s):

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

Step 3 Drug(s):

- Trudhesa (dihydroergotamine mesylate) nasal spray
- Onzetra Xsail (sumatriptan succinate) nasal powder
- Tosymra (sumatriptan) nasal spray
- Zembrace SymTouch (sumatriptan succinate) subcutaneous pen injector

Step Therapy Requirements

Step 1 Drug(s):

- Naratriptan HCl oral tablet
- Rizatriptan benzoate oral tablet
- Rizatriptan benzoate orally disintegrating tablet
- Sumatriptan succinate oral tablet

Step 2 Drug(s):

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

Step Therapy Criteria

1. Is the request for a step 2 medication?
 - a. If yes continue to #2
 - b. If no, continue to #4



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

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.