Actinic Keratosis Agents
Step Therapy Guidelines

Affected Medication(s)

- Diclofenac sodium topical gel
- Solaraze (diclofenac sodium) topical gel
- Zyclara (imiquimod) topical cream pack
- Zyclara (imiquimod) topical cream metered dose pump

Step Therapy Requirements

Step 1 Drug(s):

- Imiquimod topical cream pack

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
Effective Date: 1/1/19

Adzenys ER® (Amphetamine)
Step Therapy Guidelines

Affected Medication(s)

- Adzenys ER oral suspension

Step Therapy Requirements

Step 1 Drug(s):

- Dextroamphetamine sulfate oral solution
- Methylphenidate HCl oral solution

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
Effective Date: 1/1/19

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
Effective Date: 1/1/19, 5/1/19

Anticoagulant Agents
Step Therapy Guidelines

Affected Medication(s)

- Pradaxa (dabigatran etexilate mesylate) oral capsule
- Savaysa (edoxaban tosylate) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Eliquis (apixaban) oral tablet
- Xarelto (rivaroxaban) oral tablet

Step Therapy Criteria

1. Prescription claim for TWO Step 1 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
Effective Date: 1/1/19

Antidepressant Agents
Step Therapy Guidelines

Affected Medication(s)

- Desvenlafaxine ER oral tablet
- Desvenlafaxine fumarate ER oral tablet
- Fetzima (levomilnacipran HCl) SA oral capsule
- Forfivol XL (bupropion HCl) ER oral tablet
- Irenka (duloxetine HCl) DR oral capsule
- Khedezla (desvenlafaxine) ER oral tablet
- Marplan (isocarboxazid) oral tablet
- Pexeva (paroxetine mesylate) oral tablet
- Surmontil (trimipramine maleate) oral capsule
- Trimipramine maleate oral capsule
- Trintellix (vortioxetine hydrobromide) oral tablet
- Viibryd (vilazodone HCl) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Citalopram hydrobromide oral tablet
- Desvenlafaxine succinate ER oral tablet
- Escitalopram oxalate oral tablet
- Fluoxetine HCl oral tablet
- Fluvoxamine maleate oral tablet
- Paroxetine HCl oral tablet
- Sertraline HCl oral tablet
- Venlafaxine HCl oral tablet
- Duloxetine HCl oral capsule

Step Therapy Criteria

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

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
Effective Date: 1/1/19

Antiemetic Agents
Step Therapy Guidelines

Affected Medication(s)

- Aprepitant oral capsule
- Emend (aprepitant) oral capsule
- Emend (aprepitant) oral suspension

Step Therapy Requirements

Step 1 Drug(s):

- Ondansetron HCl oral tablet
- Ondansetron ODT 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
Effective Date: 1/1/19

Antiglaucoma Agents
Step Therapy Guidelines

Affected Medication(s)

- Azopt (brinzolamide) ophthalmic drops
- Cosopt PF (dorzolamide HCl-timolol maleate) ophthalmic droperette
- Lumigan (bimatoprost) ophthalmic drops
- Rescula (unoprostone isopropyl) ophthalmic drops
- Rhopressa (netarsudil mesylate) ophthalmic drops
- Travatan Z (travoprost) ophthalmic drops
- Vyzulta (latanoprostene bunod) ophthalmic drops
- Zioptan (tafluprost) ophthalmic droperette

Step Therapy Requirements

Step 1 Drug(s):

- Brimonidine drops
- Carteolol drops
- Dorzolamide drops
- Latanoprost drops
- Levobunolol drops
- Timolol maleate drops

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
Effective Date: 1/1/19, 5/1/19

Antihypertensive Agents
Step Therapy Guidelines

Affected Medication(s)

- Atacand (candesartan cilexetil) oral tablet
- Atacand HCT (candesartan cilexetil-hydrochlorothiazide) oral tablet
- Azor (amlodipine besylate-olmesartan medoxomil) oral tablet
- Benicar (olmesartan medoxomil) oral tablet
- Benicar HCT (olmesartan medoxomil-hydrochlorothiazide) oral tablet
- Edarbi (azilsartan medoxomil) oral tablet
- Edarbyclor (azilsartan medoxomil-chlorthalidone) oral tablet
- Exforge (amlodipine besylate-valsartan) oral tablet
- Micardis HCT (telmisartan-hydrochlorothiazide) oral tablet
- 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
- Tribenzor (olmesartan medoxomil-amlodipine besylate-hydrochlorothiazide) oral tablet
- Twynsta (telmisartan-amlodipine besylate) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Candesartan cilexetil oral tablet
- Candesartan-hydrochlorothiazide oral tablet
- Irbesartan oral tablet
- Irbesartan-hydrochlorothiazide oral tablet
- Losartan potassium oral tablet
- Losartan-hydrochlorothiazide oral tablet
- 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
Effective Date: 1/1/19

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:
Effective Date:

Atypical Antipsychotic Agents
Step Therapy Guidelines

Affected Medication(s)

- Fanapt (iloperidone) oral tablet)
- Invega (paliperidone) ER oral tablet
- Paliperidone ER oral tablet
- Rexulti (brexpiprazole) oral tablet
- Saphris (asenapine maleate) sublingual tablet

Step Therapy Requirements

Step 1 Drug(s):

- Olanzapine oral tablet
- Quetiapine fumarate oral tablet
- Risperidone oral tablet

Step Therapy Criteria

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

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
Effective Date: 1/1/19

Beta-Blocker Agents
Step Therapy Guidelines

Affected Medication(s)

- Dutoprol (metoprolol succinate-hydrochlorothiazide) ER oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Bisoprolol fumarate-hydrochlorothiazide oral tablet
- Metoprolol tartrate-hydrochlorothiazide oral tablet
- Nadolol-bendroflumethiazide oral tablet
- Propranolol HCl-hydrochlorothiazide oral tablet
- Metoprolol succinate ER oral tablet

Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days (Note: 90 days of claims history required for authorization)
    a. If yes, approve for 12 months
    b. If no, continue to #2
2. If no claim history of Step 1 Drug(s), documentation of trial, intolerance or contraindication to TWO Step 1 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
Effective Date: 1/1/19

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
Effective Date: 1/1/19

Clindacin® (clindamycin phosphate)
Step Therapy Guidelines

Affected Medication(s)

- Clindacin ETZ (clindamycin phosphate) topical swab
- Clindacin P (clindamycin phosphate) topical swab

Step Therapy Requirements

Step 1 Drug(s):

- Clindamycin phosphate topical gel
- Clindamycin phosphate topical solution
- Clindamycin phosphate topical lotion

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
Effective Date: 1/1/19

ConZip® (tramadol HCl)
Step Therapy Guidelines

Affected Medication(s)

- ConZip (tramadol HCl) oral capsule

Step Therapy Requirements

Step 1 Drug(s):

- Tramadol 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
Effective Date: 1/1/19

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 fumarate oral tablet
- Carvedilol oral tablet
- Metoprolol succinate ER 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
Effective Date: 1/1/19

Dificid® (fidaxomicin)
Step Therapy Guidelines

Affected Medication(s)

- Dificid (fidaxomicin) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Metronidazole oral tablet
- Vancomycin 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
Effective Date: 1/1/19

Dipeptidyl Peptidase-4 Enzyme Inhibitor Agents
Step Therapy Guidelines

Affected Medication(s)

- Jentadueto (linagliptin-metformin HCl) oral tablet
- Jentadueto XR (linagliptin-metformin HCl) oral tablet
- Tradjenta (linagliptin) oral tablet
- Alogliptin benzoate oral tablet
- Alogliptin benzoate-pioglitazone HCl oral tablet
- Janumet (sitagliptin phosphate-metformin HCl) oral tablet
- Janumet XR (sitagliptin phosphate-metformin HCl) oral tablet
- Januvia (sitagliptin phosphate) oral tablet
- Kazano (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

Step Therapy Requirements

Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER oral tablet

Step 2 Drug(s):

- 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
- Janumet (sitagliptin phosphate-metformin HCl) oral tablet
- Janumet XR (sitagliptin phosphate-metformin HCl) oral tablet
- Januvia (sitagliptin phosphate) oral tablet
- Kazano (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

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 Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
    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

Last Reviewed: 10/3/18
Effective Date: 1/1/19

a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
b. If no, clinical review required

3. Prescription claim for ONE Step 2 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 #4

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

    a. If yes, approve 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
Effective Date: 1/1/19

Evzio® (naloxone HCl)
Step Therapy Guidelines

Affected Medication(s)

- Evzio (naloxone HCl) auto injector

Step Therapy Requirements

Step 1 Drug(s):

- Naloxone HCl syringe
- Naloxone HCl vial
- Narcan (naloxone HCl) nasal spray

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
Effective Date: 1/1/19

Fabior® (tazarotene)
Step Therapy Guidelines

Affected Medication(s)

- Fabior (tazarotene) topical foam

Step Therapy Requirements

Step 1 Drug(s):

- Avita (tretinoin) topical cream
- Avita (tretinoin) topical gel
- Tretinoin topical cream
- Tretinoin topical gel

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
Effective Date: 1/1/19

Giazo® (balsalazide disodium)
Step Therapy Guidelines

Affected Medication(s)

- Giazo (balsalazide disodium) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Balsalazide disodium 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, 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
Effective Date: 1/1/19

Glucagon-Like Peptide-1 Agonist Agents
Step Therapy Guidelines

Affected Medication(s)

Step 2 Drug(s):

- Adlyxin (lixisenatide) subcutaneous pen injector
- Bydureon Pen (exenatide microspheres) subcutaneous pen injector
- Bydureon (exenatide microspheres) vial for subcutaneous injection
- Bydureon BCise (exenatide microspheres) subcutaneous auto injector
- Byetta (exenatide) subcutaneous pen injector
- Tanzeum (albiglutide) subcutaneous pen injector
- Trulicity (dulaglutide) subcutaneous pen injector
- Victoza 2-Pak (liraglutide) subcutaneous pen injector
- Victoza 3-Pak (liraglutide) subcutaneous pen injector

Step 3 Drug(s):

- Ozempic (semaglutide) subcutaneous pen injector

Step Therapy Requirements

Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER tablet

Step 2 Drug(s):

- Adlyxin (lixisenatide) subcutaneous pen injector
- Bydureon Pen (exenatide microspheres) subcutaneous pen injector
- Bydureon (exenatide microspheres) vial
- Bydureon BCise (exenatide microspheres) subcutaneous auto injector
- Byetta (exenatide) subcutaneous pen injector
- Tanzeum (albiglutide) subcutaneous pen injector
- Trulicity (dulaglutide) subcutaneous pen injector
- Victoza 2-Pak (liraglutide) subcutaneous pen injector
- Victoza 3-Pak (liraglutide) subcutaneous pen injector

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 Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
    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 Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
    b. If no, clinical review required

Last Reviewed: 10/3/18
Effective Date: 1/1/19

3. Prescription claim for TWO Step 2 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 #4

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

    a. If yes, approve 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.

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

Affected Medication(s)

- AirDuo RespiClick (fluticasone propionate-salmeterol xinafoate) inhalation powder

Step Therapy Requirements

Step 1 Drug(s):

- Advair Diskus (fluticasone propionate-salmeterol xinafoate) inhalation powder
- Advair HFA (fluticasone propionate-salmeterol xinafoate) inhalation aerosol
- Breo Ellipta (fluticasone furoate-vilanterol trifenatate) inhalation powder

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
Effective Date: 1/1/19

Insomnia Agents
Step Therapy Guidelines

Affected Medication(s)

- Edluar (zolpidem tartrate) sublingual tablet
- Rozerem (ramelteon) oral tablet
- Silenor (doxepin HCl) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Eszopiclone oral tablet
- 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
Effective Date: 1/1/19

Istalol® (timolol maleate)
Step Therapy Guidelines

Affected Medication(s)

- Istalol (timolol maleate) ophthalmic drops

Step Therapy Requirements

Step 1 Drug(s):

- Timolol maleate ophthalmic drops

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
Effective Date: 1/1/19

Jalyn® (dutasteride-tamsulosin HCl)
Step Therapy Guidelines

Affected Medication(s)

- Dutasteride-tamsulosin HCl oral capsule
- Jalyn (dutasteride-tamsulosin HCl) oral capsule

Step Therapy Requirements

Step 1 Drug(s):

- Finasteride oral tablet
- Tamsulosin 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
Effective Date: 1/1/19

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

Affected Medication(s)

- Stiolto Respimat (tiotropium bromide-olodaterol HCl) inhalation spray

Step Therapy Requirements

Step 1 Drug(s):

- Incruse Ellipta (umeclidinium bromide) inhalation powder

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
Effective Date: 1/1/19

Long-Acting Beta Agonist Agents
Step Therapy Guidelines

Affected Medication(s)

- Arcapta Neohaler (indacaterol maleate) inhalation powder
- Brovana (arformoterol tartrate) inhalation solution
- Foradil (formoterol fumarate) inhalation powder
- Perforomist (formoterol fumarate) inhalation solution

Step Therapy Requirements

Step 1 Drug(s):

- Serevent Diskus (salmeterol xinafoate) inhalation powder

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
Effective Date: 1/1/19

Long-Acting Antimuscarinic Agents
Step Therapy Guidelines

Affected Medication(s)

- Tudorza Pressair (aclidinium bromide) inhalation powder

Step Therapy Requirements

Step 1 Drug(s):

- Incruse Ellipta (umeclidinium bromide) inhalation powder

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
Effective Date: 1/1/19

Long-Acting Insulin Agents
Step Therapy Guidelines

Affected Medication(s)

- Basaglar Kwikpen U-100 (insulin glargine) subcutaneous insulin pen
- Levemir (insulin detemir) subcutaneous vial
- Levemir Flextouch (insulin detemir) subcutaneous insulin pen
- Tresiba Flextouch U-100 (insulin degludec) subcutaneous insulin pen
- Tresiba Flextouch U-200 (insulin degludec) subcutaneous insulin pen

Step Therapy Requirements

Step 1 Drug(s):

- Lantus (insulin glargine) subcutaneous vial
- Lantus Solostar (insulin glargine) subcutaneous insulin pen
- Toujeo Max Solostar (insulin glargine) subcutaneous insulin pen
- Toujeo Solostar (insulin glargine) subcutaneous insulin 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
Effective Date: 1/1/19

Long-Acting Opioid Agents
Step Therapy Guidelines

Affected Medication(s)

- Oxycodone HCl 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 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
Effective Date: 1/1/19

Lyrica® (pregabalin)
Step Therapy Guidelines

Affected Medication(s)

- Lyrica (pregabalin) oral capsule
- Lyrica (pregabalin) oral solution
- Lyrica CR (pregabalin) oral 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
Effective Date: 1/1/19

Metoclopramide ODT
Step Therapy Guidelines

Affected Medication(s)

- Metoclopramide HCl ODT tablet
- Metozolv ODT (metoclopramide HCl) tablet

Step Therapy Requirements

Step 1 Drug(s):

- Metoclopramide HCl oral tablet
- Metoclopramide HCl oral solution

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
Effective Date: 1/1/19

Miscellaneous Oral Diabetic Agents
Step Therapy Guidelines

Affected Medication(s)

- Actoplus MET XR (pioglitazone HCl-metformin HCl) oral tablet
- Cycloset (bromocriptine mesylate) oral tablet
- Duetact (pioglitazone HCl-glimepiride) oral tablet
- Pioglitazone HCl-glimepiride oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER 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
Effective Date: 1/1/19

Namenda XR® (memantine HCl)
Step Therapy Guidelines

Affected Medication(s)

- Memantine HCl ER oral capsule
- Namenda XR (memantine HCl) oral capsule

Step Therapy Requirements

Step 1 Drug(s):

- Memantine 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
Effective Date: 1/1/19

Namzaric® (memantine HCl-donepezil HCl)
Step Therapy Guidelines

Affected Medication(s)

- Namzaric (memantine HCl-donepezil HCl) oral capsule

Step Therapy Requirements

Step 1 Drug(s):

- Memantine HCl oral tablet
- Donepezil HCl oral tablet
- Donepezil HCl ODT 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
Effective Date: 1/1/19

Nasal Steroid Agents
Step Therapy Guidelines

Affected Medication(s)

- Beconase AQ (beclomethasone dipropionate) nasal spray
- Dymista (azelastine HCl-fluticasone propionate) nasal spray
- Nasonex (mometasone furoate) nasal spray
- Omnaris (ciclesonide) nasal spray
- Patanase (olopatadine HCl) nasal spray
- Qnasl (beclomethasone dipropionate) nasal aerosol
- Qnasl Children (beclomethasone dipropionate) nasal aerosol
- Rhinocort Aqua (budesonide) nasal spray
- Veramyst (fluticasone furoate) nasal spray
- Zetonna (ciclesonide) nasal aerosol

Step Therapy Requirements

Step 1 Drug(s):

- Budesonide nasal spray
- Flunisolide nasal spray
- Fluticasone propionate nasal spray
- Triamcinolone acetonide nasal spray

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
Effective Date: 1/1/19

Noctiva® (desmopressin acetate)
Step Therapy Guidelines

Affected Medication(s)

- Noctiva (desmopressin acetate) nasal spray

Step Therapy Requirements

Step 1 Drug(s):

- Desmopressin acetate oral tablet
- Flavoxate HCl 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
Effective Date: 1/1/19

NSAID Agents
Step Therapy Guidelines

Affected Medication(s)

- Sprix (ketorolac tromethamine) nasal spray
- Vivlodex (meloxicam, submicronized) oral capsule

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
- Naproxen oral tablet
- Naproxen DR oral tablet
- Oxaprozin oral tablet
- Sulindac oral tablet
- Tolmetin sodium 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 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
Effective Date: 1/1/19

Onmel® (itraconazole)
Step Therapy Guidelines

Affected Medication(s)

- Onmel (itraconazole) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Itraconazole 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, 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
Effective Date: 1/1/19

Overactive Bladder Agents
Step Therapy Guidelines

Affected Medication(s)

- Darifenacin ER oral tablet
- Enablex (darifenacin hydrobromide) ER oral tablet
- Gelnique (oxybutynin chloride) transdermal gel pump
- Gelnique (oxybutynin chloride) transdermal gel packet
- Myrbetriq (mirabegron) ER oral tablet
- Oxytrol (oxybutynin) transdermal patch
- Toviaz (fesoterodine fumarate) ER oral tablet
- Vesicare (solifenacin succinate) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Oxybutynin chloride oral tablet
- Oxybutynin chloride ER oral tablet
- Tolterodine tartrate oral tablet
- Trospium chloride 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
Effective Date: 1/1/19

Proton Pump Inhibitor Agents
Step Therapy Guidelines

Affected Medication(s)

- Aciphex Sprinkle (rabeprazole sodium) DR oral tablet
- Dexilant (dexlansoprazole) DR oral capsule
- Nexium (esomeprazole magnesium) DR oral capsule
- Nexium (esomeprazole magnesium) DR oral suspension packet
- Prevacid (lansoprazole) DR oral tablet
- Prilosec (omeprazole magnesium) DR oral suspension packet
- Protonix (pantoprazole sodium) DR oral granule packet
- Zegerid (omeprazole-sodium bicarbonate) oral packet

Step Therapy Requirements

Step 1 Drug(s):

- Lansoprazole DR oral capsule
- Omeprazole DR oral capsule
- Pantoprazole sodium 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
Effective Date: 1/1/19

Pramipexole ER
Step Therapy Guidelines

Affected Medication(s)

- Mirapex ER (pramipexole dihydrochloride) ER oral tablet
- Pramipexole ER oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Pramipexole dihydrochloride 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
Effective Date: 1/1/19

Rosacea Agents
Step Therapy Guidelines

Affected Medication(s)

- Mirvaso (brimonidine tartrate) topical gel
- Mirvaso (brimonidine tartrate) topical gel pump
- Rhofade (oxymetazoline HCl) topical cream
- Rosadan (metronidazole-skin cleanser combination no. 23) topical cream kit
- Rosadan (metronidazole-skin cleanser combination no. 23) topical gel kit

Step Therapy Requirements

Step 1 Drug(s):

- Metronidazole topical cream
- Metronidazole topical lotion
- Metronidazole topical gel pump
- Metronidazole topical gel

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
Effective Date: 1/1/19

Short-Acting Beta Agonist Agents
Step Therapy Guidelines

Affected Medication(s)

- Proair HFA (albuterol sulfate) inhalation aerosol
- Proair RespiClick (albuterol sulfate) inhalation powder
- Proventil HFA (albuterol sulfate) inhalation aerosol
- Xopenex HFA (levalbuterol tartrate) inhalation aerosol

Step Therapy Requirements

Step 1 Drug(s):

- Ventolin HFA (albuterol sulfate) inhalation aerosol

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
Effective Date: 1/1/19

Sodium-Glucose Cotransporter-2 Inhibitors
Step Therapy Guidelines

Affected Medication(s)

Step 2 Drug(s):

- 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

Step 3 Drug(s):

- Glyxambi (empagliflozin-linagliptin) oral tablet
- Invokamet (canagliflozin-metformin HCl) oral tablet
- Invokamet XR (canagliflozin-metformin HCl) oral tablet
- Invokana (canagliflozin) oral tablet
- Qtern (dapagliflozin propanediol-saxagliptin HCl) oral tablet
- Segluromet (ertugliflozin pidolate-metformin HCl) oral tablet
- Stegletro (ertugliflozin pidolate) oral tablet
- Steglujan (ertugliflozin pidolate-sitagliptin phosphate) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Metformin HCl oral tablet
- Metformin HCl ER tablet

Step 2 Drug(s):

- 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

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 Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
    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 Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
    b. If no, clinical review required

Last Reviewed: 10/3/18
Effective Date: 1/1/19

3. Prescription claim for ONE Step 2 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 #4

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

    a. If yes, approve 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:
Effective Date:

Sitavig® (acyclovir)
Step Therapy Guidelines

Affected Medication(s)

- Sitavig (acyclovir) buccal tablet

Step Therapy Requirements

Step 1 Drug(s):

- Acyclovir oral capsule
- Acyclovir oral tablet
- Famciclovir oral tablet
- Valacyclovir HCl 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
Effective Date: 1/1/19

Soriatane® (acitretin)
Step Therapy Guidelines

Affected Medication(s)

- Acitretin oral capsule
- Soriatane (acitretin) oral capsule

Step Therapy Requirements

Step 1 Drug(s):

- Avita (tretinoin) topical cream
- Avita (tretinoin) topical gel
- Tretinoin topical cream
- Tretinoin topical gel

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
Effective Date: 1/1/19

Spritam® (levetiracetam)
Step Therapy Guidelines

Affected Medication(s)

- Spritam (levetiracetam) oral tablet for suspension

Step Therapy Requirements

Step 1 Drug(s):

- Levetiracetam oral tablet
- Levetiracetam oral solution
- Levetiracetam vial
- Levetiracetam ER 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
Effective Date: 1/1/19

Statin Agents
Step Therapy Guidelines

Affected Medication(s)

- Fluvastatin sodium ER oral tablet
- Fluvastatin sodium oral capsule
- Livalo (pitavastatin calcium) oral tablet
- Zypitamag (pitavastatin magnesium) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Atorvastatin calcium oral tablet
- Lovastatin oral tablet
- Pravastatin sodium oral tablet
- Rosuvastatin calcium oral tablet
- Simvastatin oral tablet

Step Therapy Criteria

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

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

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

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

Note:

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Last Reviewed: 10/3/18
Effective Date: 1/1/19

Sumaxin® (levetiracetam)
Step Therapy Guidelines

Affected Medication(s)

- Sumaxin CP (sulfacetamide-sulfur-skin cleanser combo no. 23) topical kit

Step Therapy Requirements

Step 1 Drug(s):

- Sodium sulfacetamide-sulfur topical cleanser

Step Therapy Criteria

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

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

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

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

Note:

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Last Reviewed: 10/3/18
Effective Date: 1/1/19

Tetracycline Antibiotic Agents
Step Therapy Guidelines

Affected Medication(s)

- Doryx (doxycycline hyclate) DR oral tablet
- Doryx MPC (doxycycline hyclate) DR oral tablet
- Doxycycline hyclate DR oral tablet
- Oracea (doxycycline monohydrate) oral capsule
- Soloxide (doxycycline hyclate) DR oral tablet
- Targadox (doxycycline hyclate) oral tablet
- Ximino (minocycline HCl) ER oral capsule

Step Therapy Requirements

Step 1 Drug(s):

- Doxycycline monohydrate oral capsule
- Doxycycline monohydrate oral tablet
- Minocycline HCl oral capsule
- Minocycline HCl oral tablet

Step Therapy Criteria

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

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

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

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

Note:

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Last Reviewed: 10/3/18
Effective Date: 1/1/19

Topical Acne Combination Agents
Step Therapy Guidelines

Affected Medication(s)

- Clindamycin phosphate-tretinoin topical gel
- Veltin (clindamycin phosphate-tretinoin) topical gel
- Ziana (clindamycin phosphate-tretinoin) topical gel

Step Therapy Requirements

Step 1 Drug(s):

- Avita (tretinoin) topical cream
- Avita (tretinoin) topical gel
- Tretinoin topical cream
- Tretinoin topical gel

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
Effective Date: 1/1/19

Topical Acne Agents
Step Therapy Guidelines

Affected Medication(s)

- Acanya (clindamycin phosphate-benzoyl peroxide) topical gel pump
- Onexton (clindamycin phosphate-benzoyl peroxide) topical gel pump

Step Therapy Requirements

Step 1 Drugs:

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

Step Therapy Criteria

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

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

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

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

Note:

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Last Reviewed: 10/3/18
Effective Date: 1/1/19

Topical Antibiotic Agents
Step Therapy Guidelines

Affected Medication(s)

- Altabax 1% ointmemt
- Xepi 1% cream

Step Therapy Requirements

Step 1 Drug(s):

- Mupirocin 2% cream
- Mupirocin 2% ointment

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: 1/16/19
Effective Date: 2/15/19

Topical Anti-Inflammatory Agents
Step Therapy Guidelines

Affected Medication(s)

- Avage (tazarotene) topical cream
- Doxepin topical cream
- Eucrisa (crisaborole) topical ointment
- Tazorac (tazarotene) topical gel

Step Therapy Requirements

Step 1 Drug(s):

- Betamethasone dipropionate topical cream
- Betamethasone dipropionate topical lotion
- Betamethasone dipropionate topical ointment
- Betamethasone dipropionate augmented (betamethasone dipropionate-propylene glycol) topical cream
- Betamethasone dipropionate augmented (betamethasone dipropionate-propylene glycol) topical lotion
- Betamethasone dipropionate augmented (betamethasone dipropionate-propylene glycol) topical ointment
- Betamethasone valerate topical cream
- Betamethasone valerate topical lotion
- Betamethasone valerate topical ointment
- Clobetasol propionate topical cream
- Clobetasol propionate topical ointment
- Clobetasol propionate topical solution
- Clobetasol propionate topical lotion
- Desoximetasone topical cream
- Desoximetasone topical gel
- Desoximetasone topical ointment
- Fluocinonide topical cream
- Fluocinonide topical gel
- Fluocinonide topical ointment
- Fluocinonide topical solution
- Fluocinonide-E (fluocinonide-emollient base) topical cream
- Halobetasol propionate topical cream
- Halobetasol propionate topical 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

Last Reviewed: 10/3/18
Effective Date: 1/1/19

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:
Effective Date:

Topical NSAID Agents
Step Therapy Guidelines

Affected Medication(s)

- Flector (diclofenac epolamine) topical patch
- Pennsaid (diclofenac sodium) topical solution

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
- Naproxen oral tablet
- Naproxen DR oral tablet
- Oxaprozin oral tablet
- Sulindac oral tablet
- Tolmetin sodium oral capsule
- Diclofenac sodium topical gel

Step Therapy Criteria

1. Prescription claim for ONE prescription strength oral NSAID Step 1 Drug AND diclofenac sodium gel 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
Effective Date: 1/1/19

Topical Vitamin A Derivatives
Step Therapy Guidelines

Affected Medication(s)

- Atralin (tretinoin) topical gel
- Differin (adapalene) topical cream
- Differin (adapalene) topical gel
- Differin (adapalene) topical gel pump
- Epiduo (adapalene-benzoyl peroxide) topical gel pump
- Retin-A (tretinoin) topical cream
- Retin-A (tretinoin) topical gel
- Retin-A-Micro (tretinoin microspheres) topical gel
- Retin-A-Micro Pump (tretinoin microspheres) topical gel
- Tazorac topical cream
- Tazorac topical gel
- Tretinoin microsphere topical gel
- Tretinoin microsphere topical gel pump
- Tretin-X (tretinoin) topical cream
- Tretin-X (tretinoin-emollient combination no. 9-skin cleanser no.1) topical combo package

Step Therapy Requirements

Step 1 Drug(s):

- Adapalene topical cream
- Adapalene topical gel
- Adapalene topical gel pump
- Adapalene-benzoyl peroxide topical gel pump
- Avita (tretinoin) topical cream
- Avita (tretinoin) topical gel
- Tretinoin topical cream
- Tretinoin topical gel

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

Last Reviewed: 10/3/18
Effective Date: 1/1/19

Note:

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Last Reviewed:
Effective Date:

Triptan Agents
Step Therapy Guidelines

Affected Medication(s)

Step 2 Drug(s):

- Almotriptan malate oral tablet
- Axert (almotriptan malate) oral tablet
- Eletriptan hydrobromide oral tablet
- Frova (frovatriptan succinate) oral tablet
- Frovatriptan succinate oral tablet
- Migranal (dihydroergotamine mesylate) nasal spray
- Onzetra Xsail (sumatriptan succinate) nasal powder
- Relpax (eletriptan hydrobromide) oral tablet
- Sumatriptan succinate-naproxen sodium oral tablet
- Sumatriptan nasal spray
- Treximet (sumatriptan succinate-naproxen sodium) oral tablet

Step 3 Drug(s):

- 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
- Axert (almotriptan malate) oral tablet
- Eletriptan hydrobromide oral tablet
- Frova (frovatriptan succinate) oral tablet
- Frovatriptan succinate oral tablet
- Migranal (dihydroergotamine mesylate) nasal spray
- Onzetra Xsail (sumatriptan succinate) nasal powder
- Relpax (eletriptan hydrobromide) oral tablet
- Sumatriptan succinate-naproxen sodium oral tablet
- Sumatriptan nasal spray
- Treximet (sumatriptan succinate-naproxen sodium) oral tablet

Step Therapy Criteria

1. Prescription claim for TWO Step 1 Drug(s) within the past 180 days

    a. If yes, approve Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
    b. If no, continue to #2

Last Reviewed: 10/3/18
Effective Date: 1/1/19

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 Step 2 Drug for 12 months. For Step 3 Drug request continue to #3
    b. If no, clinical review required

3. Prescription claim for ONE Step 2 Drug(s) within the past 90 days (Note: 30 days of claims 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 Drug is required

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

Note:

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Last Reviewed: 10/3/18
Effective Date: 1/1/19

Trulance® (plecanatide)
Step Therapy Guidelines

Affected Medication(s)

- Trulance (plecanatide) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Amitiza (lubiprostone) 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, approve for 12 months
    b. If no, continue to #2

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

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

Note:

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Last Reviewed: 10/3/18
Effective Date: 1/1/19

Zenzedi® (dextroamphetamine sulfate)
Step Therapy Guidelines

Affected Medication(s)

- Zenzedi (dextroamphetamine sulfate) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Dexmethylphenidate HCl oral tablet
- Dextroamphetamine-amphetamine oral tablet
- Dextroamphetamine sulfate oral tablet
- Methylphenidate 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
Effective Date: 1/1/19

Zodex® (dexamethasone)
Step Therapy Guidelines

Affected Medication(s)

- Zodex (dexamethasone) oral tablet

Step Therapy Requirements

Step 1 Drug(s):

- Dexamethasone oral tablet
- Dexamethasone oral elixir

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
Effective Date: 1/1/19