

## Step Therapy Criteria

<b>Step Therapy Group</b>	ARIPIPRAZOLE ODT
<b>Drug Names</b>	ARIPIPRAZOLE ODT
<b>Step Therapy Criteria</b>	Coverage will be provided if generic aripiprazole immediate release tablet has been tried (at least a 30-day supply in the prior 180 days).
<b>Step Therapy Group</b>	BARACLUDE SOL
<b>Drug Names</b>	BARACLUDE
<b>Step Therapy Criteria</b>	Coverage will be provided if generic entecavir tablets have been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	BENIGN PROSTATIC HYPERPLASIA
<b>Drug Names</b>	CARDURA XL
<b>Step Therapy Criteria</b>	Coverage will be provided if terazosin, alfuzosin, doxazosin, silodosin or tamsulosin has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	BISPHOSPHONATES
<b>Drug Names</b>	ALENDRONATE SODIUM, ATELVIA, BINOSTO, FOSAMAX PLUS D, RISEDRONATE SODIUM DR
<b>Step Therapy Criteria</b>	Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	DPP4 INHIBITORS
<b>Drug Names</b>	ALOGLIPTIN, ALOGLIPTIN/METFORMIN HCL, ALOGLIPTIN/METFORMIN HYDR, ALOGLIPTIN/PIOGLITAZONE, KAZANO, KOMBIGLYZE XR, NESINA, ONGLYZA, OSENI, SITAGLIPTIN, SITAGLIPTIN/METFORMIN HYD, ZITUVIO
<b>Step Therapy Criteria</b>	Coverage will be provided if the patient had a trial of at least a 30 day supply each of sitagliptin (Januvia [sitagliptin], Janumet [sitagliptin/metformin hydrochloride], or Janumet XR [sitagliptin/metformin hydrochloride extended-release]) AND linagliptin (Tradjenta [linagliptin], Jentadueto [linagliptin/metformin hydrochloride], or Jentadueto XR [linagliptin/metformin hydrochloride extended-release]) in the prior 180 days.
<b>Step Therapy Group</b>	EDARBI-EDARBYCLOR
<b>Drug Names</b>	EDARBI, EDARBYCLOR
<b>Step Therapy Criteria</b>	Coverage will be provided if two formulary generic Angiotensin II Receptor Antagonists (ARBs) or ARB combination products have been tried (at least a 30-day supply in the prior 180 days).

<b>Step Therapy Group</b>	HMG-COA INHIBITORS
<b>Drug Names</b>	ALTOPREV, ATORVALIQ, EZALLOR SPRINKLE, FLOLIPID, FLUVASTATIN, FLUVASTATIN SODIUM ER, LESCOL XL, LIVALO, PITAVASTATIN CALCIUM, ZYPITAMAG
<b>Step Therapy Criteria</b>	Coverage will be provided if atorvastatin tablets, ezetimibe/simvastatin, lovastatin, pravastatin, rosuvastatin tablets, simvastatin tablets, or amlodipine/atorvastatin has been tried (at least a 30-day supply) in the prior 180 days.
<b>Step Therapy Group</b>	LAMOTRIGINE
<b>Drug Names</b>	LAMICTAL ODT, LAMICTAL XR, LAMOTRIGINE ER, LAMOTRIGINE ODT
<b>Step Therapy Criteria</b>	Coverage will be provided if generic lamotrigine immediate release tablets or generic lamotrigine chewable, dispersible tablet has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	LEVALBUTEROL
<b>Drug Names</b>	LEVALBUTEROL TARTRATE HFA, XOPENEX HFA
<b>Step Therapy Criteria</b>	Coverage will be provided if albuterol HFA or Ventolin HFA have been tried (at least a 30-day supply) in the prior 180 days.
<b>Step Therapy Group</b>	LEVOTHYROXINE
<b>Drug Names</b>	LEVOTHYROXINE SODIUM, TIROSINT
<b>Step Therapy Criteria</b>	Coverage will be provided if levothyroxine tablets have been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	NASAL STEROIDS - PENDING CMS REVIEW
<b>Drug Names</b>	OMNARIS, QNASL, QNASL CHILDRENS
<b>Step Therapy Criteria</b>	-
<b>Step Therapy Group</b>	OLANZAPINE ODT
<b>Drug Names</b>	OLANZAPINE ODT, ZYPREXA ZYDIS
<b>Step Therapy Criteria</b>	Coverage will be provided if generic olanzapine immediate release tablet has been tried (at least a 30-day supply in the prior 180 days).
<b>Step Therapy Group</b>	PPI
<b>Drug Names</b>	ESOMEPRAZOLE MAGNESIUM, LANSOPRAZOLE, NEXIUM, PANTOPRAZOLE SODIUM, PREVACID SOLUTAB, PROTONIX
<b>Step Therapy Criteria</b>	Coverage will be provided if two of the following generic alternatives: omeprazole capsules, pantoprazole tablets, or lansoprazole capsules have been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	PROSTAGLANDINS
<b>Drug Names</b>	IYUZEH, XELPROS, ZIOPTAN
<b>Step Therapy Criteria</b>	Coverage will be provided if latanoprost, bimatoprost, or travoprost has been tried (at least a 30-day supply) in the prior 180 days.

<b>Step Therapy Group</b>	RISPERIDONE ODT
<b>Drug Names</b>	RISPERIDONE ODT
<b>Step Therapy Criteria</b>	Coverage will be provided if generic risperidone immediate release tablet has been tried (at least a 30-day supply in the prior 180 days).
<b>Step Therapy Group</b>	RYTARY
<b>Drug Names</b>	RYTARY
<b>Step Therapy Criteria</b>	Coverage will be provided if a generic immediate-release or extended-release carbidopa-levodopa containing product has been tried for at least 30 days in the prior 180 days.
<b>Step Therapy Group</b>	TOPICAL ANTIFUNGALS
<b>Drug Names</b>	ERTACZO, LULICONAZOLE, LUZU
<b>Step Therapy Criteria</b>	Coverage will be provided if econazole cream or ketoconazole cream has been tried (at least a 30 day supply) in the prior 180 days.
<b>Step Therapy Group</b>	TRIPTANS
<b>Drug Names</b>	ALMOTRIPTAN, ELETRIPTAN HYDROBROMIDE, FROVA, FROVATRIPTAN SUCCINATE, ONZETRA XSAIL, RELPAX, SUMATRIPTAN/NAPROXEN SODI, TOSYMRA, TREXIMET, ZEMBRACE SYMTOUCH, ZOLMITRIPTAN, ZOLMITRIPTAN ODT, ZOMIG
<b>Step Therapy Criteria</b>	Coverage will be provided if generic naratriptan, rizatriptan, rizatriptan orally disintegrating tablets (ODT), sumatriptan nasal spray, sumatriptan tablets, OR sumatriptan injection has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	URINARY ANTISPASMODICS
<b>Drug Names</b>	DARIFENACIN HYDROBROMIDE, DETROL LA, GELNIQUE, OXYTROL, TOLTERODINE TARTRATE ER
<b>Step Therapy Criteria</b>	Coverage will be provided if one of the following generics has been tried (at least a 30-day supply in the prior 180 days): oxybutynin tablets, oxybutynin solution, oxybutynin extended-release tablets, solifenacin tablets, tolterodine immediate-release tablets, or trospium immediate-release tablets.