

Step Therapy Criteria

Step Therapy Group 5-ASA
Drug Names DIPENTUM, LIALDA
Step Therapy Criteria You are required to have previous therapy with balsalazide, Delzicol, Apriso, or Asacol HD before we will cover Lialda or Dipentum.

Step Therapy Group ANTIEMETICS
Drug Names GRANISETRON HCL, SANCUSO
Step Therapy Criteria You are required to have previous therapy with oral ondansetron before we will cover granisetron oral tablet or granisetron transdermal (Sancuso).

Step Therapy Group BETA AGONIST INHALERS
Drug Names LEVALBUTEROL TARTRATE HFA
Step Therapy Criteria You are required to have previous therapy with Ventolin HFA before we will cover levalbuterol HFA.

Step Therapy Group BETASERON AND REBIF
Drug Names BETASERON, REBIF, REBIF REBIDOSE, REBIF REBIDOSE TITRATION, REBIF TITRATION PACK
Step Therapy Criteria You are required to have previous therapy with (1) glatiramer (Copaxone) AND (2) either interferon beta-1a (Avonex) or peginterferon beta-1a (Plegridy) before we will cover interferon beta-1b (Betaseron) or interferon beta-1a (Rebif).

Step Therapy Group BISPHOSPHONATES
Drug Names RISEDRONATE SODIUM, RISEDRONATE SODIUM DR
Step Therapy Criteria You are required to have previous therapy with a generic oral bisphosphonate (e.g. alendronate or ibandronate) before we will cover risedronate (generic for Actonel or Atelvia).

Step Therapy Group CLONAZEPAM ODT
Drug Names CLONAZEPAM ODT
Step Therapy Criteria You are required to have previous therapy with clonazepam before we will cover clonazepam ODT.

<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>CLOZAPINE ODT</p> <p>CLOZAPINE ODT</p> <p>You are required to have previous therapy with clozapine tablets before we will cover clozapine ODT (Fazaclo).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>DAPAGLIFLOZIN</p> <p>FARXIGA, XIGDUO XR</p> <p>You are required to have previous therapy with one canagliflozin-containing drug (e.g., Invokana, Invokamet) AND one empagliflozin-containing drug (e.g., Jardiance, Glyxambi, Synjardy) before we will cover dapagliflozin (Farxiga) or dapagliflozin/metformin (Xigduo XR).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>DESVENLAFAXINE</p> <p>DESVENLAFAXINE ER, KHEDEZLA, PRISTIQ</p> <p>You are required to have previous therapy with venlafaxine (IR or ER) AND 1 selective serotonin reuptake inhibitor (SSRI) such as sertraline or paroxetine (Paxil) before we will cover desvenlafaxine ER (Khedezla, Pristiq).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>FEBUXOSTAT</p> <p>ULORIC</p> <p>You are required to have previous therapy with allopurinol before we will cover febuxostat (Uloric).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>FIDAXOMICIN</p> <p>DIFICID</p> <p>You are required to have previous therapy with oral or intravenous vancomycin or oral metronidazole before we will cover fidaxomicin (Difcid).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>GLP-1 RECEPTOR AGONISTS</p> <p>BYDUREON, BYDUREON PEN, BYETTA</p> <p>You are required to have previous therapy with Trulicity or Victoza before we will cover Byetta or Bydureon.</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>HYPNOTIC</p> <p>ZALEPLON, ZOLPIDEM TARTRATE</p> <p>You are required to have previous therapy with 1 of the following medications before we will cover zolpidem or zaleplon: trazodone, Rozerem, or Silenor.</p>

<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>OPHTHALMIC PROSTAGLANDINS</p> <p>BIMATOPROST, TRAVATAN Z, ZIOPTAN</p> <p>You are required to have previous therapy with latanoprost before we will cover bimatoprost, Travatan Z, or tafluprost (Zioptan).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PANCREATIC ENZYMES</p> <p>PANCREAZE, PERTZYE, VIOKACE, ZENPEP</p> <p>You are required to have previous therapy with Creon before we will cover Pancreaze, Viokace, or Zenpep.</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PROTON PUMP INHIBITORS</p> <p>DEXILANT</p> <p>You are required to have previous therapy with prescription omeprazole, lansoprazole, or pantoprazole before we will cover dexlansoprazole (Dexilant).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>SYMLIN</p> <p>SYMLINPEN 120, SYMLINPEN 60</p> <p>You are required to have previous therapy with insulin before we will cover Symlin.</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>TEKTURNA</p> <p>TEKTURNA, TEKTURNA HCT</p> <p>You are required to have previous therapy with an angiotensin-converting enzyme (ACE) inhibitor (e.g. lisinopril), or an ACE inhibitor combination product (e.g. lisinopril-HCTZ), or an angiotensin II Receptor Blocker (ARB)(e.g. Losartan), or an ARB combination product (e.g. Losartan-HCT) before we will cover Tekturna or Tekturna HCT.</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>TERIPARATIDE</p> <p>FORTEO</p> <p>You are required to have previous therapy with a bisphosphonate (e.g. alendronate) or raloxifene before we will cover teriparatide (Forteo).</p>