

## **Step Therapy Criteria**

**Step Therapy Group** ADCIRCA  
**Drug Names** ADCIRCA  
**Step Therapy Criteria** Coverage will be provided if the member has filled a prescription for sildenafil (at least a 30 day supply within the past 365 days)

**Step Therapy Group** ANTIPSYCHOTICS 657-D  
**Drug Names** FANAPT, FANAPT TITRATION PACK, LATUDA, REXULTI, SAPHRIS  
**Step Therapy Criteria** Coverage will be provided if the member has filled a prescription for a 30 day supply of aripiprazole, olanzapine, risperidone, quetiapine regular release, or ziprasidone within the past 180 days

**Step Therapy Group** ELIDEL 76-F  
**Drug Names** ELIDEL  
**Step Therapy Criteria** Coverage will be provided if the member is at least two years of age AND the member has filled a prescription for at least one topical corticosteroid of medium or higher potency (at least a 14 day supply within the past 180 days)

**Step Therapy Group** ERGOMAR 1510-D  
**Drug Names** ERGOMAR  
**Step Therapy Criteria** Coverage will be provided if the patient has filled a prescription for a 7 day supply of generic ergotamine, generic dihydroergotamine, or generic 5-HT<sub>1</sub> agonists (triptans) within the past 120 days

**Step Therapy Group** EXELDERM 1380-D  
**Drug Names** EXELDERM  
**Step Therapy Criteria** Coverage will be provided if the patient has filled a prescription for a 7 day supply of a generic topical antifungal agent within the past 120 days

**Step Therapy Group** INTUNIV 781-D  
**Drug Names** GUANFACINE ER  
**Step Therapy Criteria** Coverage will be provided if the member has filled a prescription for an amphetamine-dextroamphetamine, dextroamphetamine, methamphetamine, lisdexamfetamine, methylphenidate or dexmethylphenidate product (at least a 30 day supply within the past 180 days)

<b>Step Therapy Group</b>	LYRICA 656-D
<b>Drug Names</b>	LYRICA
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has filled a prescription for regular release generic gabapentin (at least a 30 day supply within the past 120 days)
<b>Step Therapy Group</b>	NY OTC ALTABAX/CENTANY 1076-D
<b>Drug Names</b>	ALTABAX, CENTANY AT
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has filled a prescription for generic mupirocin (at least a 5 day supply within the past 180 days)
<b>Step Therapy Group</b>	NY OTC ANTI-LICE 1080-D
<b>Drug Names</b>	SKLICE, ULESFIA
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has filled a prescription for generic OTC permethrin (at least a 14 day supply within the past 60 days)
<b>Step Therapy Group</b>	NY OTC ANTIFUNGALS TOPICAL 1079-D
<b>Drug Names</b>	CICLOPIROX, CICLOPIROX NAIL LACQUER, CICLOPIROX OLAMINE, CLOTRIMAZOLE, ECONAZOLE NITRATE, KETOCONAZOLE, NAFTIFINE HCL, NAFTIFINE HYDROCHLORIDE, NAFTIN, OXICONAZOLE NITRATE, OXISTAT
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has filled a prescription for a generic OTC clotrimazole 1% topical cream OR OTC miconazole 2% topical cream/lotion/oint/soln OR OTC butenafine 1% topical cream OR OTC tolnaftate 1% topical cream/powder/spray/soln (at least a 14 day supply within the past 180 days)
<b>Step Therapy Group</b>	NY OTC ANTIFUNGALS TOPICAL KETODAN 1079-D
<b>Drug Names</b>	KETODAN
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has tried a generic OTC clotrimazole 1% topical cream OR OTC miconazole 2% topical cream/lotion/oint/soln OR OTC butenafine 1% topical cream (14 days within the past 180 days)
<b>Step Therapy Group</b>	NY OTC ANTIFUNGALS TOPICAL NYSTATIN 1079-D
<b>Drug Names</b>	NYAMYC, NYSTATIN, NYSTOP
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has tried a generic OTC clotrimazole 1% topical cream OR OTC miconazole 2% topical cream/lotion/oint/soln (14 days within the past 180 days)

<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>NY OTC ANTIHISTAMINES NON-SEDATING 1081-D</p> <p>CLARINEX, DESLORATADINE, DESLORATADINE ODT</p> <p>Coverage will be provided if the member has filled a prescription for generic OTC loratadine, fexofenadine, or cetirizine (at least a 14 day supply within the past 180 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>NY OTC ANTIVIRALS - TOPICAL 1075-D</p> <p>DENAVIR</p> <p>Coverage will be provided if the member has filled a prescription for oral acyclovir, valacyclovir, famciclovir OR OTC Abreva (at least a 1 day supply within the past 180 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>NY OTC CORTISPORIN 1076-D</p> <p>CORTISPORIN</p> <p>Coverage will be provided if the member has filled a prescription for generic OTC NEOMYCIN-BACITRACIN-POLYMYXIN OINTMENT (at least a 5 day supply within the past 180 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>NY OTC OPHTHALMICS ANTIHISTAMINE 1082-D</p> <p>AZELASTINE HCL, BEPREVE, EMADINE, EPINASTINE HCL, LASTACAFT, OLOPATADINE HCL, PATADAY</p> <p>Coverage will be provided if the member has filled a prescription for generic OTC Zaditor (at least a 14 day supply within the past 180 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>NY OTC PROTON PUMP INHIBITORS 1078-D</p> <p>DEXILANT</p> <p>Coverage will be provided if the member has filled a prescription for an OTC generic Proton Pump Inhibitor or Nexium OTC (at least a 30 day supply within the past 180 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>NY OTC TOPICAL ACNE 1077-D</p> <p>BENZAMYCINPAK, BENZIQU, BENZIQU LS, BENZOYL PEROXIDE WASH, BP WASH, CLEARPLEX X, EPIDUO, EPIDUO FORTE, OSCION CLEANSER</p> <p>Coverage will be provided if the member has filled a prescription for an OTC benzoyl peroxide product (at least a 30 day supply within the past 180 days)</p>

<b>Step Therapy Group</b>	PDPD AUTOIMMUNE
<b>Drug Names</b>	ACTEMRA, COSENTYX, COSENTYX SENSOREADY PEN, KINERET, ORENCIA, ORENCIA CLICKJECT, SIMPONI, SIMPONI ARIA, STELARA, XELJANZ
<b>Step Therapy Criteria</b>	Must try Enbrel or Humira
<b>Step Therapy Group</b>	PDPD MS
<b>Drug Names</b>	PLEGRIDY, PLEGRIDY STARTER PACK
<b>Step Therapy Criteria</b>	Must try Betaseron, Rebif, Copaxone 40mg, Glatopa 20mg, Gilenya, Tecfidera or Aubagio
<b>Step Therapy Group</b>	PROTOPIC 177-F
<b>Drug Names</b>	TACROLIMUS
<b>Step Therapy Criteria</b>	Protopic 0.03%: Coverage will be provided if the member is at least two years of age AND filled a prescription for at least one topical corticosteroid of medium or higher potency (at least a 14 day supply within 180 days) Protopic 0.1%: Coverage will be provided if the member is at least 16 years of age AND filled a prescription for at least one topical corticosteroid of medium or higher potency (at least a 14 day supply within 180 days)
<b>Step Therapy Group</b>	RANEXA 658-D
<b>Drug Names</b>	RANEXA
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has filled a prescription for a nitrate plus a beta blocker or a calcium channel blocker (at least a 30 day supply within the past 365 days)
<b>Step Therapy Group</b>	SIMVA 80MG 981-D
<b>Drug Names</b>	SIMVASTATIN
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has filled a prescription for 80mg strength of simvastatin (Zocor) (at least a 290 day supply within the past 365 days)
<b>Step Therapy Group</b>	SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR (SGLT2) AND SGLT2 INHIBITOR / METFORMIN 676-D
<b>Drug Names</b>	INVOKANA
<b>Step Therapy Criteria</b>	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin, OR a sulfonyleurea, OR a thiazolidinedione within the past 180 days

<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TGST ACNE 771-D</p> <p>ACANYA, AZELEX</p> <p>Coverage will be provided if the member has filled a prescription for a generic acne product (at least a 30 day supply within the past 180 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TGST ARB/RI 376-D</p> <p>EDARBI, TEKTURNA</p> <p>Coverage will be provided if the member has filled a prescription for a generic ACE, ACE/HCTZ combination, ARB, or ARB/HCTZ combination (at least a 30 day supply within the past 365 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TGST BPH-ALPHA1 BLCK 606-D</p> <p>CARDURA XL, RAPAFLO</p> <p>Coverage will be provided if the member has filled a prescription for a generic Benign Prostatic Hyperplasia (BPH) agent (e.g., alfuzosin ext-rel, doxazosin, tamsulosin, terazosin) (at least a 30 day supply within the past 365 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TGST PROSTAGL ANALOG 613-D</p> <p>LUMIGAN, TRAVATAN Z, ZIOPTAN</p> <p>Coverage will be provided if the member has filled a prescription for a generic prostaglandin analogue (at least a 30 day supply within the past 365 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TGST SLEEP AGENTS 382-D</p> <p>BELSOMRA, ROZEREM</p> <p>Coverage will be provided if the member has filled a prescription for a generic nonbenzodiazepine hypnotic (at least a 30 day supply within the past 180 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TGST SSRI 384-D</p> <p>VIIBRYD, VIIBRYD STARTER PACK</p> <p>Coverage will be provided if the member has filled a prescription for a generic SSRI product (at least a 30 day supply within the past 365 days)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TGST TRIPTANS 391-D</p> <p>RELPAX</p> <p>Coverage will be provided if the member has filled a prescription for a generic 5HT 1 Agonist (triptan) (at least a 30 day supply within the past 180 days)</p>

**Step Therapy Group**  
**Drug Names**  
**Step Therapy Criteria**

TGST URINARY ANTISPASMODICS 385-D  
MYRBETRIQ, OXYTROL, VESICARE  
Coverage will be provided if the member has filled a prescription for a generic urinary antispasmodic (at least a 30 day supply within the past 180 days)

**Step Therapy Group**  
**Drug Names**  
**Step Therapy Criteria**

ULORIC 540-D  
ULORIC  
Coverage will be provided if the member has filled a prescription for allopurinol (at least a 30 day supply within the past 180 days)

**Step Therapy Group**  
**Drug Names**  
**Step Therapy Criteria**

VANCOCIN 513-E  
VANCOMYCIN HCL  
Coverage will be provided if the member has filled a prescription for metronidazole (at least a 10 day supply within the past 60 days) OR, Vancocin capsules - vancomycin hydrochloride (at least a 7 day supply within the past 60 days) OR, a 10 day supply of Dificid within the past 60 days. Note: Dificid requires a prior authorization.