

Step Therapy Criteria

Step Therapy Group ADCIRCA 1772-D
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 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 DOXEPIN 1496-E
Drug Names DOXEPIN HYDROCHLORIDE
Step Therapy Criteria Coverage will be provided if the member has filled a prescription for at least a 7 day supply of a generic topical corticosteroid AND at least a 7 day supply of topical tacrolimus (Protopic) or Elidel (pimecrolimus) within the past 120 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 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)

Step Therapy Group	LYRICA 656-D
Drug Names	LYRICA
Step Therapy Criteria	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)
Step Therapy Group	NY OTC ALTABAX/CENTANY 1076-D
Drug Names	ALTABAX, CENTANY AT
Step Therapy Criteria	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)
Step Therapy Group	NY OTC ANTI-LICE 1080-D
Drug Names	SKLICE, ULESFIA
Step Therapy Criteria	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)
Step Therapy Group	NY OTC ANTIFUNGALS TOPICAL 1079-D
Drug Names	CICLOPIROX, CICLOPIROX OLAMINE, CLOTRIMAZOLE, ECONAZOLE NITRATE, KETOCONAZOLE, NAFTIFINE HCL, NAFTIFINE HYDROCHLORIDE, OXICONAZOLE NITRATE, OXISTAT
Step Therapy Criteria	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)
Step Therapy Group	NY OTC ANTIFUNGALS TOPICAL KETODAN 1079-D
Drug Names	KETODAN
Step Therapy Criteria	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)
Step Therapy Group	NY OTC ANTIFUNGALS TOPICAL NYSTATIN 1079-D
Drug Names	NYAMYC, NYSTATIN, NYSTOP
Step Therapy Criteria	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>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</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>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</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>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</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>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>NY OTC OPHTHALMICS ANTIHISTAMINE 1082-D</p> <p>AZELASTINE HCL, BEPREVE, EMADINE, EPINASTINE HCL, LASTACAFT, OLOPATADINE HCL, OLOPATADINE HYDROCHLORIDE</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>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>NY OTC PROTON PUMP INHIBITORS 1078-D</p> <p>DEXILANT, ESOMEPRAZOLE MAGNESIUM</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>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>NY OTC TOPICAL ACNE 1077-D</p> <p>ADAPALENE AND BENZOYL PER, BENZIQ, BENZIQ LS, BP FOAMING WASH, BP WASH, CLEARPLEX X, 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>

Step Therapy Group	OPIOID ER 2219-M
Drug Names	BELBUCA, EMBEDA, FENTANYL, HYDROMORPHONE HCL ER, HYSINGLA ER, METHADONE HCL, METHADONE HCL INTENSOL, MORPHINE SULFATE ER, NUCYNTA ER, OXYCODONE HCL ER, OXYCONTIN, OXYMORPHONE HYDROCHLORIDE, TRAMADOL HCL ER
Step Therapy Criteria	Coverage will be provided if the member has filled a cumulative 7-day or greater supply of an immediate-release opioid agent within the past 90 days OR has been receiving an extended-release opioid agent for a cumulative 30 days or greater within the past 90 days.
Step Therapy Group	OPIOID IR 2221-M
Drug Names	CODEINE SULFATE, HYDROMORPHONE HCL, LEVORPHANOL TARTRATE, MORPHINE SULFATE, NUCYNTA, OXYCODONE HCL, OXYMORPHONE HYDROCHLORIDE, TRAMADOL HCL
Step Therapy Criteria	Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.
Step Therapy Group	OPIOID IR COMBO PRODUCTS 1358-E
Drug Names	ACETAMINOPHEN/CODEINE, CAPITAL/CODEINE, ENDOCET, HYDROCODONE BITARTRATE/AC, HYDROCODONE/ACETAMINOPHEN, LORTAB, OXYCODONE/ACETAMINOPHEN, OXYCODONE/ASPIRIN, OXYCODONE/IBUPROFEN, PRIMLEV, XYLON
Step Therapy Criteria	Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.
Step Therapy Group	PDPD AUTOIMMUNE
Drug Names	ACTEMRA, ORENCIA, ORENCIA CLICKJECT, SIMPONI, SIMPONI ARIA, XELJANZ
Step Therapy Criteria	Must try Enbrel or Humira
Step Therapy Group	PDPD HEP C
Drug Names	SOVALDI, ZEPATIER
Step Therapy Criteria	Must try Epclusa or Harvoni

<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PDPD MS</p> <p>AVONEX, AVONEX PEN, PLEGRIDY, PLEGRIDY STARTER PACK</p> <p>Must try Betaseron, Rebif, Copaxone 40mg, Glatopa 20mg, Gilenya, Tecfidera or Aubagio</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PDPD OSTEOPOROSIS</p> <p>FORTEO</p> <p>Must try Prolia</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PRISTIQ 1888-D</p> <p>DESVENLAFAXINE ER</p> <p>Coverage will be provided if the patient has filled a prescription for a 30 day supply of a generic serotonin-norepinephrine reuptake inhibitor (SNRI) OR generic mirtazapine, generic bupropion, or a generic selective serotonin reuptake inhibitor (SSRI) within the past 120 days.</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PROTOPIC 177-F</p> <p>TACROLIMUS</p> <p>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)</p> <p>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)</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>RANEXA 658-D</p> <p>RANEXA</p> <p>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)</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>SIMVA 80MG 981-D</p> <p>SIMVASTATIN</p> <p>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)</p>

Step Therapy Group	SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR (SGLT2) AND SGLT2 INHIBITOR / METFORMIN 676-D
Drug Names	JARDIANCE
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin, OR a sulfonylurea, OR a thiazolidinedione within the past 180 days
Step Therapy Group	TGST ACNE 771-D
Drug Names	ACANYA, AZELEX
Step Therapy Criteria	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)
Step Therapy Group	TGST ARB/RI 376-D
Drug Names	EDARBI, TEKTURNA
Step Therapy Criteria	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)
Step Therapy Group	TGST BISPHOSPHONATES 377-D
Drug Names	FOSAMAX PLUS D
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a generic bisphosphonate product (at least a 28 day supply within the past 365 days)
Step Therapy Group	TGST BPH-ALPHA1 BLCK 606-D
Drug Names	CARDURA XL, RAPAFLO
Step Therapy Criteria	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)
Step Therapy Group	TGST PROSTAGL ANALOG 613-D
Drug Names	LUMIGAN, TRAVATAN Z, ZIOPTAN
Step Therapy Criteria	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)
Step Therapy Group	TGST SLEEP AGENTS 382-D
Drug Names	BELSOMRA, ROZEREM
Step Therapy Criteria	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)

Step Therapy Group	TGST SSRI 384-D
Drug Names	TRINTELLIX, VIIBRYD, VIIBRYD STARTER PACK
Step Therapy Criteria	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)
Step Therapy Group	TGST URINARY ANTISPASMODICS 385-D
Drug Names	MYRBETRIQ, VESICARE
Step Therapy Criteria	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	ULORIC 540-D
Drug Names	ULORIC
Step Therapy Criteria	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	VANCOCIN 513-E
Drug Names	VANCOMYCIN HCL
Step Therapy Criteria	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.