

## **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)

<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 OLAMINE, CLOTRIMAZOLE, ECONAZOLE NITRATE, KETOCONAZOLE, NAFTIFINE HCL, NAFTIFINE HYDROCHLORIDE, 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, 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><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, 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><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>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**  
**Drug Names**

OPIOID ER 2219-M  
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**  
**Drug Names**

OPIOID IR 2221-M  
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**  
**Drug Names**

OPIOID IR COMBO PRODUCTS 1358-E  
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**  
**Drug Names**

PDPD AUTOIMMUNE  
ACTEMRA, ORENCIA, ORENCIA CLICKJECT, SIMPONI, SIMPONI ARIA, XELJANZ  
**Step Therapy Criteria**  
For Rheumatoid Arthritis, try Enbrel, Humira, Kevzara. For Ankylosing Spondylitis, try Cosentyx, Enbrel, Humira. For Psoriatic Arthritis, try Cosentyx, Enbrel, Humira, Otezla, Stelara. For Crohn's, try Humira or Stelara. For Ulcerative Colitis, try Humira. For Plaque Psoriasis, try Cosentyx, Enbrel, Humira, Otezla, Stelara.

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

PDPD HEP C  
SOVALDI, ZEPATIER

**Step Therapy Criteria**

Must try Epclusa or Harvoni

<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></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><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>PDPD OSTEOPOROSIS</p> <p>FORTEO</p> <p>Must try Prolia</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></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><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></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><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></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><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></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>

<b>Step Therapy Group</b>	SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR (SGLT2) AND SGLT2 INHIBITOR / METFORMIN 676-D
<b>Drug Names</b>	JARDIANCE
<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 sulfonylurea, OR a thiazolidinedione within the past 180 days
<b>Step Therapy Group</b>	TGST ACNE 771-D
<b>Drug Names</b>	ACANYA, AZELEX
<b>Step Therapy Criteria</b>	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)
<b>Step Therapy Group</b>	TGST ARB/RI 376-D
<b>Drug Names</b>	EDARBI, TEKTURNA
<b>Step Therapy Criteria</b>	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)
<b>Step Therapy Group</b>	TGST BISPHOSPHONATES 377-D
<b>Drug Names</b>	FOSAMAX PLUS D
<b>Step Therapy Criteria</b>	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)
<b>Step Therapy Group</b>	TGST BPH-ALPHA1 BLCK 606-D
<b>Drug Names</b>	CARDURA XL, RAPAFLO
<b>Step Therapy Criteria</b>	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)
<b>Step Therapy Group</b>	TGST PROSTAGL ANALOG 613-D
<b>Drug Names</b>	LUMIGAN, TRAVATAN Z, ZIOPTAN
<b>Step Therapy Criteria</b>	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)
<b>Step Therapy Group</b>	TGST SLEEP AGENTS 382-D
<b>Drug Names</b>	BELSOMRA, ROZEREM
<b>Step Therapy Criteria</b>	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><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>TRINTELLIX, 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 URINARY ANTISPASMODICS 385-D</p> <p>MYRBETRIQ, VESICARE</p> <p>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)</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>ULORIC 540-D</p> <p>ULORIC</p> <p>Coverage will be provided if the member has filled a prescription for allopurinol (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>VANCOCIN 513-E</p> <p>VANCOMYCIN HCL</p> <p>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.</p>