

Step Therapy Criteria

Step Therapy Group	BENIGN PROSTATIC HYPERPLASIA
Drug Names	CARDURA XL
Step Therapy Criteria	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).
Step Therapy Group	BISPHOSPHONATES
Drug Names	BINOSTO, FOSAMAX PLUS D
Step Therapy Criteria	Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).
Step Therapy Group	DPP4 INHIBITORS
Drug Names	ALOGLIPTIN, ALOGLIPTIN/METFORMIN HCL, ALOGLIPTIN/METFORMIN HYDR, ALOGLIPTIN/PIOGLITAZONE, KOMBIGLYZE XR, ONGLYZA
Step Therapy Criteria	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.
Step Therapy Group	HMG-COA INHIBITORS
Drug Names	ALTOPREV, EZALLOR SPRINKLE, FLOLIPID, LIVALO, ZYPITAMAG
Step Therapy Criteria	Coverage will be provided if atorvastatin, ezetimibe/simvastatin, fluvastatin, fluvastatin extended-release, lovastatin, pravastatin, rosuvastatin tablets, simvastatin tablets, or amlodipine/atorvastatin has been tried (at least a 30-day supply) in the prior 180 days.
Step Therapy Group	LEVALBUTEROL
Drug Names	LEVALBUTEROL TARTRATE HFA
Step Therapy Criteria	Coverage will be provided if albuterol HFA or Ventolin HFA have been tried (at least a 30-day supply) in the prior 180 days.
Step Therapy Group	LEVOTHYROXINE CAP
Drug Names	LEVOTHYROXINE SODIUM
Step Therapy Criteria	Coverage will be provided if levothyroxine tablets have been tried (at least a 30 day supply in the prior 180 days).
Step Therapy Group	NASAL STEROIDS
Drug Names	BECONASE AQ, MOMETASONE FUROATE, OMNARIS, QNASL, QNASL CHILDRENS, ZETONNA
Step Therapy Criteria	Coverage will be provided if generic fluticasone nasal spray has been tried (at least a 30-day supply) in the prior 180 days.

<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PPI</p> <p>ESOMEPRAZOLE MAGNESIUM, LANSOPRAZOLE, PANTOPRAZOLE SODIUM</p> <p>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).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>PROSTAGLANDINS</p> <p>XELPROS, ZIOPTAN</p> <p>Coverage will be provided if latanoprost, bimatoprost, or travoprost has been tried (at least a 30-day supply) in the prior 180 days.</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>RYTARY</p> <p>RYTARY</p> <p>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.</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>TRIPTANS</p> <p>ONZETRA XSAIL, TOSYMRA, ZEMBRACE SYMTOUCH</p> <p>Coverage will be provided if almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, rizatriptan ODT, sumatriptan nasal spray, sumatriptan tabs, sumatriptan injection, zolmitriptan tabs, OR zolmitriptan ODT has been tried (at least a 30 day supply in the prior 180 days).</p>
<p>Step Therapy Group</p> <p>Drug Names</p> <p>Step Therapy Criteria</p>	<p>URINARY ANTISPASMODICS</p> <p>DARIFENACIN HYDROBROMIDE, GELNIQUE, OXYTROL, TOLTERODINE TARTRATE ER</p> <p>Coverage will be provided if fesoterodine, mirabegron, oxybutynin, oxybutynin extended-release, solifenacin tablets, tolterodine tablets, trospium immediate-release, or vibegron has been tried (at least a 30-day supply in the prior 180 days).</p>