

## Step Therapy Criteria

<b>Step Therapy Group</b>	BENIGN PROSTATIC HYPERPLASIA
<b>Drug Names</b>	CARDURA XL
<b>Step Therapy Criteria</b>	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).
<b>Step Therapy Group</b>	BISPHOSPHONATES
<b>Drug Names</b>	BINOSTO, FOSAMAX PLUS D
<b>Step Therapy Criteria</b>	Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	ESOMEPRAZOLE
<b>Drug Names</b>	ESOMEPRAZOLE MAGNESIUM
<b>Step Therapy Criteria</b>	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).
<b>Step Therapy Group</b>	HMG-COA INHIBITORS
<b>Drug Names</b>	ALTOPREV, FLOLIPID, LIVALO, ZYPITAMAG
<b>Step Therapy Criteria</b>	Coverage will be provided if atorvastatin, ezetimibe/simvastatin, fluvastatin, fluvastatin extended-release, lovastatin, pravastatin, rosuvastatin, simvastatin tablets, or amlodipine/atorvastatin has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	PROSTAGLANDINS
<b>Drug Names</b>	VYZULTA, XELPROS, ZIOPTAN
<b>Step Therapy Criteria</b>	Coverage will be provided if latanoprost, bimatoprost, or travoprost has been tried (at least a 30-day supply in the prior 180 days).
<b>Step Therapy Group</b>	TRIPTANS
<b>Drug Names</b>	ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG
<b>Step Therapy Criteria</b>	Coverage will be provided if almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, rizatriptan ODT, sumatriptan nasal spray, sumatriptan tabs, sumatriptan injection, sumatriptan/naproxen, zolmitriptan OR zolmitriptan ODT has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	URINARY ANTISPASMODICS
<b>Drug Names</b>	GELNIQUE PUMP, OXYTROL, TOLTERODINE TARTRATE, TOLTERODINE TARTRATE ER
<b>Step Therapy Criteria</b>	Coverage will be provided if oxybutynin, oxybutynin extended-release, fesoterodine, trospium immediate-release or mirabegron has been tried (at least a 30 day supply in the prior 180 days).