Select 2019 Formulary
2019 Step Therapy Criteria
ANTIDEPRESSANTS

Products Affected

Step 2:

- FORFIVO XL TABLET EXTENDED RELEASE 24 HOUR 450 MG ORAL
- PEXEVA TABLET 10 MG ORAL
- PEXEVA TABLET 20 MG ORAL
- PEXEVA TABLET 30 MG ORAL
- PEXEVA TABLET 40 MG ORAL

Details

Criteria	Claim will pay automatically for Pexeva or Forfivo XL if enrollee has a paid claim for at least a 1 days supply of any 2 generic formulary antidepressants in the past 365 days. Otherwise, Pexeva or Forfivo XL requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 2 generic formulary antidepressants, OR (2) history of adverse event with any 2 generic formulary antidepressants, OR (3) any 2 generic formulary antidepressants are contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

BASAL GLP

Products Affected

Step 2:

- SOLIQUA SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML SUBCUTANEOUS
- XULTOPHY SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML SUBCUTANEOUS

Details

Criteria	Claim will pay automatically for Xultophy or Soliqua if enrollee has a paid claim for at least a one day supply of any step level 1 agent (LANTUS, LEVEMIR, OZEMPIC, TOUJEO, TRESIBA, TRULICITY OR VICTOZA). Otherwise, Xultophy or Soliqua require a step therapy exception request indicating: (1) history of inadequate treatment response with step 1 agent, OR (2) history of adverse event with step 1 agent, OR (3) step 1 agent is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

CELECOXIB

Products Affected

Step 2:

- *celecoxib capsule 100 mg oral*
- *celecoxib capsule 200 mg oral*
- *celecoxib capsule 400 mg oral*
- *celecoxib capsule 50 mg oral*

Details

Criteria	Claim will pay automatically for Celecoxib if enrollee has a paid claim for at least a 1 days supply of any generic oral formulary NSAID in the past 365 days. Otherwise, Celecoxib requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic oral formulary NSAID, OR (2) history of adverse event with any generic oral formulary NSAID, OR (3) any generic oral formulary NSAID is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

DHE

Products Affected

Step 2:

- *dihydroergotamine mesylate solution 4 mg/ml nasal*

Details

Criteria	Claim will pay automatically for DHE if enrollee has a paid claim for at least a 1 days supply of any generic formulary serotonin (5-HT) 1b/1d receptor agonist (i.e. triptan) in the past 365 days. Otherwise, DHE requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary triptan, OR (2) history of adverse event with any generic formulary triptan, OR (3) any generic formulary triptan is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

DIFICID

Products Affected

Step 2:

- DIFICID TABLET 200 MG ORAL

Details

Criteria	Claim will pay automatically for Dificid if enrollee has a paid claim for at least a 1 days supply of Vancomycin in the past 120 days. Otherwise, Dificid requires a step therapy exception request indicating: (1) history of inadequate treatment response with Vancomycin, OR (2) history of adverse event with Vancomycin, OR (3) Vancomycin is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

ESA

Products Affected

Step 2:

- ARANESP (ALBUMIN FREE) SOLUTION 100 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION 200 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION 25 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION 300 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION 40 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION 60 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 25 MCG/0.42ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 40 MCG/0.4ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 500 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 60 MCG/0.3ML INJECTION
- EPOGEN SOLUTION 10000 UNIT/ML INJECTION
- EPOGEN SOLUTION 2000 UNIT/ML INJECTION
- EPOGEN SOLUTION 20000 UNIT/ML INJECTION
- EPOGEN SOLUTION 3000 UNIT/ML INJECTION
- EPOGEN SOLUTION 4000 UNIT/ML INJECTION

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR ARANESP OR EPOGEN IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF PROCRIT IN THE PAST 365 DAYS. OTHERWISE, ARANESP OR EPOGEN REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH PROCRIT, OR (2) HISTORY OF ADVERSE EVENT WITH PROCRIT, OR (3) PROCRIT IS CONTRAINDICATED.

Select 2019 Formulary
2019 Step Therapy Criteria

LIVALO

Products Affected

Step 2:

- LIVALO TABLET 1 MG ORAL
- LIVALO TABLET 2 MG ORAL
- LIVALO TABLET 4 MG ORAL

Details

Criteria	Claim will pay automatically for Livalo if enrollee has a paid claim for at least a 1 days supply of any generic formulary statin in the past 365 days. Otherwise, Livalo requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary statin, OR (2) history of adverse event with any generic formulary statin, OR (3) any generic formulary statin is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

NEUPRO

Products Affected

Step 2:

- NEUPRO PATCH 24 HOUR 1 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 2 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 3 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 4 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 6 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 8 MG/24HR TRANSDERMAL

Details

Criteria	Claim will pay automatically for neupro if enrollee has a paid claim for at least a 1 days supply of pramipexole or ropinirole in the past 365 days. Otherwise, neupro requires a step therapy exception request indicating: (1) history of inadequate treatment response with pramipexole or ropinirole, OR (2) history of adverse event with pramipexole or ropinirole, OR (3) pramipexole or ropinirole is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

PPI

Products Affected

Step 2:

- DEXILANT CAPSULE DELAYED RELEASE 30 MG ORAL
- DEXILANT CAPSULE DELAYED RELEASE 60 MG ORAL

Details

Criteria	Claim will pay automatically for Dexilant if enrollee has a paid claim for at least a 1 days supply of any 1 of the following: esomeprazole (Rx), omeprazole (Rx), lansoprazole (Rx), or pantoprazole in the past 365 days. Otherwise, Dexilant requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 1 of the following: esomeprazole (Rx), omeprazole (Rx), lansoprazole (Rx), or pantoprazole OR (2) history of adverse event with any 1 of the following: esomeprazole (Rx), omeprazole (Rx), lansoprazole (Rx), or pantoprazole, OR (3) any 1 of the following: esomeprazole (Rx), omeprazole (Rx), lansoprazole (Rx), or pantoprazole are contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

PRADAXA

Products Affected

Step 2:

- PRADAXA CAPSULE 110 MG ORAL
- PRADAXA CAPSULE 150 MG ORAL
- PRADAXA CAPSULE 75 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Pradaxa IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Xarelto or Eliquis IN THE PAST 365 DAYS. OTHERWISE, Pradaxa REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Xarelto or Eliquis, OR (2) HISTORY OF ADVERSE EVENT WITH Xarelto or Eliquis, OR (3) Xarelto or Eliquis IS CONTRAINDICATED.

Select 2019 Formulary
2019 Step Therapy Criteria

PROLIA

Products Affected

Step 2:

- PROLIA SOLUTION 60 MG/ML SUBCUTANEOUS

Details

Criteria	Claim will pay automatically for Prolia if enrollee has a paid claim for at least a 1 days supply of any formulary bisphosphonate in the past 180 days. Otherwise, Prolia requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary bisphosphonate, OR (2) history of adverse event with any formulary bisphosphonate, OR (3) any formulary bisphosphonate is contraindicated. For osteoporosis prophylaxis in men at high risk for bone fractures after receiving androgen deprivation therapy for nonmetastatic prostate cancer and in women at high risk for bone fractures after receiving adjuvant aromatase inhibitor therapy for breast cancer, Prolia will be approved.

Select 2019 Formulary
2019 Step Therapy Criteria

RYTARY

Products Affected

Step 2:

- RYTARY CAPSULE EXTENDED RELEASE 23.75-95 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 36.25-145 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 48.75-195 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 61.25-245 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR RYTARY IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT IN THE PAST 365 DAYS. OTHERWISE, RYTARY REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT, OR (2) HISTORY OF ADVERSE EVENT WITH ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT, OR (3) ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT IS CONTRAINDICATED.

SGLT2

Products Affected

Step 2:

- INVOKAMET TABLET 150-1000 MG ORAL
- INVOKAMET TABLET 150-500 MG ORAL
- INVOKAMET TABLET 50-1000 MG ORAL
- INVOKAMET TABLET 50-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL
- INVOKANA TABLET 100 MG ORAL
- INVOKANA TABLET 300 MG ORAL
- JARDIANCE TABLET 10 MG ORAL
- JARDIANCE TABLET 25 MG ORAL
- SYNJARDY TABLET 12.5-1000 MG ORAL
- SYNJARDY TABLET 12.5-500 MG ORAL
- SYNJARDY TABLET 5-1000 MG ORAL
- SYNJARDY TABLET 5-500 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR INVOKANA, INVOKAMET IR/XR, JARDIANCE, OR SYNJARDY IR/XR IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT IN THE PAST 365 DAYS. OTHERWISE, INVOKANA, INVOKAMET IR/XR, JARDIANCE, OR SYNJARDY IR/XR REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT, OR (2) HISTORY OF ADVERSE EVENT WITH GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT, OR (3) GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT IS

	CONTRAINDICATED.

TOPICAL AGENTS

Products Affected

Step 2:

- CONDYLOX GEL 0.5 % EXTERNAL

Details

Criteria	Claim will pay automatically for Condylox if enrollee has a paid claim for at least a 1 days supply of Podofilox in the past 365 days. Otherwise, Condylox requires a step therapy exception request indicating: (1) history of inadequate treatment response with podofilox OR (2) history of adverse event with podofilox OR (3) podofilox is contraindicated.

TOPICAL ANTI-INFLAMMATORY

Products Affected

Step 2:

- ELIDEL CREAM 1 % EXTERNAL
- EUCRISA OINTMENT 2 % EXTERNAL
- *tacrolimus ointment 0.03 % external*
- *tacrolimus ointment 0.1 % external*

Details

Criteria	Claim will pay automatically for Elidel, Eucrisa, or Tacrolimus External if enrollee has a paid claim for at least a 1 days supply of any formulary topical corticosteroid in the past 365 days. Otherwise, Elidel, Eucrisa, or Tacrolimus External requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary topical corticosteroid, OR (2) history of adverse event with any formulary topical corticosteroid, OR (3) any formulary topical corticosteroid is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

UCERIS

Products Affected

Step 2:

- *budesonide er tablet extended release 24 hour 9 mg oral*
- UCERIS FOAM 2 MG/ACT RECTAL

Details

Criteria	Claim will pay automatically for Budesonide ER 9mg or Uceris Rectal Foam if enrollee has a paid claim for at least a 1 days supply of any formulary corticosteroid used to treat ulcerative colitis in the past 365 days. Otherwise, Budesonide ER 9mg or Uceris Rectal Foam requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary corticosteroid used to treat ulcerative colitis, OR (2) history of adverse event with any formulary corticosteroid used to treat ulcerative colitis, OR (3) any formulary corticosteroid used to treat ulcerative colitis is contraindicated.

Select 2019 Formulary
2019 Step Therapy Criteria

ULORIC

Products Affected

Step 2:

- ULORIC TABLET 40 MG ORAL
- ULORIC TABLET 80 MG ORAL

Details

Criteria	Claim will pay automatically for Uloric if enrollee has a paid claim for at least a 1 days supply of Allopurinol in the past 365 days. Otherwise, Uloric requires a step therapy exception request indicating: (1) history of inadequate treatment response with Allopurinol, OR (2) history of adverse event with Allopurinol, OR (3) Allopurinol is contraindicated.

XTANDI

Products Affected

Step 2:

- XTANDI CAPSULE 40 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR XTANDI IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF ZYTIGA IN THE PAST 365 DAYS. OTHERWISE, XTANDI REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH ZYTIGA, OR (2) HISTORY OF ADVERSE EVENT WITH ZYTIGA, OR (3) ZYTIGA IS CONTRAINDICATED.

ZYFLO

Products Affected

Step 2:

- *zileuton er tablet extended release 12 hour 600 mg oral*
- ZYFLO TABLET 600 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Zileuton IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Montelukast or Zafirlukast IN THE PAST 365 DAYS. OTHERWISE, Zileuton REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Montelukast or Zafirlukast, OR (2) HISTORY OF ADVERSE EVENT WITH Montelukast or Zafirlukast, OR (3) Montelukast or Zafirlukast IS CONTRAINDICATED.

Select 2019 Formulary
2019 Step Therapy Criteria

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