



2018 PacificSource Health Plans Step Therapy Criteria

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(All criteria reviewed at least once per year)

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POLICY NAME:

ACE-I/ARB

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.
 If the patient has tried a Step 2 drug, then authorization for a Step 3 drug may be given.

Step 1 Drug(s): Amlodipine Besylate-benazepril, Benazepril Hcl, Benazepril-hydrochlorothiazide, Captopril, Captopril-hydrochlorothiazide, Candesartan-hydrochlorothiazide, Enalapril Maleate, Enalapril-hydrochlorothiazide, eprosartan, Fosinopril Sodium, Fosinopril-hydrochlorothiazide, Lisinopril, Lisinopril-hydrochlorothiazide, Losartan Potassium, Losartan-Hydrochlorothiazide, Moexipril Hcl, Moexipril-hydrochlorothiazide, Perindopril erbumine, Quinapril Hcl, Quinapril-hydrochlorothiazide, Ramipril, Trandolapril.

Step 2 Drug(s): Azor, Benicar, Benicar HCT

Step 3 Drug(s): Edarbi, Teveten

- Authorization may be given for a step 2 or step 3 angiotensin receptor blocker (ARB) or ARB-containing combination product, without a trial of a step 1 or 2 agent, if the patient was recently hospitalized and discharged within the previous 30 days for a cardiovascular event (eg, myocardial infarction, hypertensive emergency, decompensated heart failure) and has already been started and stabilized on the requested agent.
- Authorization may be given for Atacand in children aged less than 6 years.



POLICY NAME:

ACNE AGENTS – Acanya, Azelex

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs, then authorization for a drug in Step 2 drug may be given.

Step 1 Drug(s): benzoyl peroxide, clindamycin topical, clindamycin/benzoyl peroxide, erythromycin topical, erythromycin/benzoyl peroxide, sodium sulfacetamide, or sodium sulfacetamide/sulfur.

Step 2 Drug(s): Acanya, Azelex



POLICY NAME:

ACTICLATE

Effective Date: 01/01/2015

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried a Step 1 drug at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Doxycycline tablets

Step 2 Drug(s): Acticlate



POLICY NAME:

AMITIZA/LINZESS

Effective Date: 05/15/2015

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried one Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Enulose, Lactulose, Polyethylene Glycol 3350

Step 2 Drug(s): Amitiza, Linzess



POLICY NAME:

ANTIDEPRESSANTS – Trintellix, Desvenlafaxine ER, Fetzima, Fluoxetine 90mg weekly, Fluvoxamine ER, Pexeva, Pristiq, Symbyax, Viibryd

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes (Trintellix, desvenlafaxine ER and Fetzima are non-formulary)	Yes(Trintellix, desvenlafaxine ER and Fetzima are non-formulary)	Yes(Trintellix, desvenlafaxine ER and Fetzima are non-formulary)

If the patient has tried **TWO** Step 1 drugs, then authorization for a drug in Step 2 drug may be given.

Step 1 Drug(s): Citalopram HBr, Escitalopram Oxalate, Fluoxetine Hcl, Fluvoxamine Maleate, Paroxetine HCL, Paroxetine HCL ER, Sertraline HCL, Venlafaxine HCL, Venlafaxine ER.

Step 2 Drug(s): Trintellix, desvenlafaxine ER, Fetzima, fluoxetine 90mg weekly, Fluvoxamine Maleate ER, Pexeva, Pristiq, Symbyax, Viibryd.

- If the patient has tried **two** Step 1 drugs, then authorization may be given for a Step 2 drug.
- Patients who have taken Viibryd, Pexeva, Pristiq or desvenlafaxine at any time in the past and discontinued its use may receive authorization to restart Viibryd, Pexeva, Pristiq or desvenlafaxine(whichever they used in the past).
- Authorization may be given for Viibryd if the patient is a child or adolescent aged 18 years or less, or has suicidal ideation.
- Symptoms of suicidal ideation: approve Pexeva, Pristiq or desvenlafaxine ER without a trial of a step 1 agent.
- This step therapy program applies to new utilizers only



POLICY NAME:

ATYPICAL ANTIPSYCHOTICS – Fanapt, Invega Sustenna, Latuda, Saphris, Paliperidone ER, Quetiapine ER, Rexulti, Vraylar

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug.

Step 1 Drug(s): Aripiprazole, Olanzapine, Quetiapine, Risperidone, Ziprasidone

Step 2 Drug(s): Fanapt, Invega Sustenna, Latuda, Paliperidone ER, Quetiapine ER, Rexulti, Vraylar

- Authorization will be granted for Latuda without a trial of a step 1 agent, for treatment of bipolar depression.



POLICY NAME:

ATYPICAL ANTIPSYCHOTICS – Fanapt, Invega Sustenna, Invega ER, Latuda, Paliperidone ER, Quetiapine ER, Rexulti, Saphris, Seroquel XR, Vraylar

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug.

Step 1 Drug(s): Abilify, Aripiprazole, Geodon, Olanzapine, Quetiapine, Risperidone, Risperdal, Seroquel, Ziprasidone, Zyprexa

Step 2 Drug(s): Fanapt, Invega Sustenna, Invega ER, Latuda, Paliperidone ER, Quetiapine ER, Rexulti, Seroquel XR, Saphris, Vraylar

- Authorization will be granted for Latuda without a trial of a step 1 agent, for treatment of bipolar depression.



POLICY NAME:

BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY – Dutasteride, Dutasteride-Tamsulosin, Cardura XL, Jalyn, Rapaflo

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried one Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): finasteride, dutasteride, terazosin

Step 2 Drug(s): dutasteride-tamsulosin, Jalyn, Cardura XL, Rapaflo



POLICY NAME:
 BISPHOSPHONATES ORAL
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes (Fosamax +D Non-form)	Yes (Fosamax +D Non-form)	Yes (Fosamax +D Non-form)

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Alendronate Sodium

Step 2 Drug(s): Risedronate Sodium, Risedronate Sodium DR, Fosamax + D

- Authorization may be given for Risedronate for use in the management of Paget’s disease if the patient has started therapy with Risedronate



POLICY NAME:

BUTRANS

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

Coverage will be provided if **TWO** Step 1 drugs have been tried within the last 180 days, or there is documented rationale for avoidance, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): acetaminophen/codeine, acetaminophen/codeine #2, acetaminophen/codeine #3, acetaminophen/codeine #4, Endocet, hydrocodone/acetaminophen, hydrocodone/ibuprofen, oxycodone/acetaminophen, oxycodone/aspirin, Reprexain, tramadol, tramadol ER, tramadol ER (biphasic), tramadol/acetaminophen

Step 2 Drug(s): Butrans patch



POLICY NAME:
CALCIPOTRIENE/BETAMETHASONE TOPICALS
Effective Date: 12/01/14

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): high potency topical corticosteroid (such as betamethasone dipropionate 0.05%) **OR** calcipotriene 0.005%

Step 2 Drug(s): Taclonex suspension, Enstilar Foam



POLICY NAME:

DIFICID

Effective Date: 05/15/2015

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Vancomycin HCL capsules

Step 2 Drug(s): Difucid



POLICY NAME:

DIRECT RENIN INHIBITORS – Tekturna, Tekturna HCT

Effective Date: 09/14/2016

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs, then authorization may be given.

Step 1 Drug(s):

Amlodipine Besylate-benazepril, Atacand, Atacand Hct, Azor, Benazepril Hcl, Benazepril-hydrochlorothiazide, Benicar, Benicar Hct, Captopril, Captopril-hydrochlorothiazide, Candesartan, Candesartan-hydrochlorothiazide, Cozaar, Diovan, Diovan Hct, Edarbi, Enalapril Maleate, Enalapril-hydrochlorothiazide, eprosartan, Exforge, Exforge Hct, Fosinopril Sodium, Fosinopril-hydrochlorothiazide, Lisinopril, Lisinopril-hydrochlorothiazide, Losartan Potassium, Losartan-Hydrochlorothiazide, Lotensin, Lotensin Hct, Micardis, Micardis Hct, Moexipril Hcl, Moexipril-hydrochlorothiazide, Perinopril erbumine, Quinapril Hcl, Quinapril-hydrochlorothiazide, Ramipril, Tarka, Telmisartan, Telmisartan-Amlodipine, Teveten, Teveten Hct, Trandolapril, Tribenzor, Twynsta, Vasotec.

Step 2 Drug(s): Tekturna, Tekturna HCT



POLICY NAME:

ECOZA (econazole 1% foam)

Effective Date: 05/14/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried one Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): econazole 1% cream

Step 2 Drug(s): Ecoza

- Authorization for Ecoza may be given if the patient has a generic econazole claim within the last 180 days



POLICY NAME:

ENDARI (L-glutamine)

Effective Date: 10/11/2017

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried one Step 1 drug, (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Hydroxyurea

Step 2 Drug(s): Endari



POLICY NAME:

EZETIMIBE

Effective Date: 11/8/2017

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried ONE Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Atorvastatin, Rosuvastatin, Fluvastatin, Lovastatin, Pravastatin Sodium, Simvastatin

Step 2 Drug(s): Ezetimibe

- Authorization for Ezetimibe may be given if the patient is taking or will be taking a medication that has a significant drug interaction with any of the HMG-CoA reductase inhibitors [statins] (eg, cyclosporine, fibrates, niacin more than 1 g/day, itraconazole, ketoconazole, erythromycin, clarithromycin, HIV protease inhibitors, nefazodone, amiodarone, and verapamil).
- Authorization of Ezetimibe may be given if the patient has severe renal impairment (creatinine clearance of 30 mL/minute or less).
- Authorization of Ezetimibe may be given if for management of homozygous familial sitosterolemia.
- Authorization of Ezetimibe may be given for use in pregnant woman.
- Authorization of Ezetimibe may be given if the patient has active liver disease or unexplained persistent elevations of serum transaminases.
- Exceptions are NOT recommended for Ezetimibe for use in patients with moderate or severe hepatic insufficiency.
- As reviewed by a pharmacist, authorization for Ezetimibe may be given for use in patients who have been previously diagnosed with myopathy or rhabdomyolysis (either medication-related or not medication related) OR the patient has an underlying muscle/muscle-metabolism-related disorder (eg, myositis, McArdle disease).



POLICY NAME:

FIBRATES – Triglide

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): At least a 30 day supply of a generic fibrate within the past 365 days.

Step 2 Drug(s): Triglide



POLICY NAME:

GLUCAGON-LIKE PEPTIDE-1 AGONISTS – Victoza, Trulicity

Effective Date: 03/22/2018

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 90-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Metformin

Step 2 Drug(s): Victoza, Trulicity

- Patients with renal disease or renal dysfunction (eGFR less than 30) may be approved



POLICY NAME:

INSOMNIA AGENTS – Belsomra, Edluar, eszopiclone, Intermezzo, Lunesta, Rozerem, Silenor

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes (except Rozerem, Silenor)	Rozerem only (others are non-formulary)	Rozerem only (others are non-formulary)	Rozerem only (others are non-formulary)

If the patient has triedn **TWO Step 1 drugs**, then authorization for a Step 2 drug may be given. If the patient has tried **TWO step 2 drugs**, then authorization for a Step 3 drug may be given.

Step 1 Drugs: At least a 30 day supply of a generic hypnotic (eszopiclone,zolpidem, zaleplon, temazepam, triazolam, ect.) within the past 180 days.

Step 2 Drugs: At lease a 30 day supply of the following Edluar, Intermezzo, Lunesta brand, Rozerem, Silenor.

Step 3 Drugs: Belsomra



POLICY NAME:

Megestrol Acetate 625mg/5mL oral suspension

Effective Date: 03/15/2015

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): megestrol acetate 40mg/ml oral suspension

Step 2 Drug(s): megestrol acetate 625mg/5mL oral suspension, Megace ES (PDL Only)



POLICY NAME:

NEUROPATHIC AGENTS – Lyrica, Gralise, Horizant, Savella

Effective Date: 03/22/2018

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Gabapentin, Duloxetine

Step 2 Drug(s): Gralise, Gralise Starter, Horizant, Lyrica, Savella

- Authorization for Lyrica, without a trial of a step 1 agent, may be given for patients with symptoms of seizure disorder.
- Authorization may be given for Lyrica if the patient has tried Horizant.
- Authorization for Lyrica may be given if the patient cannot tolerate gabapentin due to adverse events.
- Authorization for Lyrica may be given, without a trial of a step 1 agent, if the patient has symptoms of fibromyalgia.
- Authorization may be given for Lyrica if the patient has symptoms of generalized anxiety disorder (GAD) and has been previously treated with two drugs from the following drug classes - tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), or buspirone.

This step therapy program applies to new utilizers only.



POLICY NAME:

NSAIDs Oral

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** unique prescription strength generic NSAIDs (meloxicam, diclofenac sodium, diclofenac potassium, etodolac, ibuprofen, indomethacin, flurbiprofen, fenoprofen calcium, ketoprofen, nabumetone, naproxen, naproxen sodium, piroxicam, tolmetin sodium, or sulindac) in the last 180 days, then authorization for step 2 drug maybe be given.

Step 1 Drug(s): meloxicam, diclofenac sodium, diclofenac potassium, etodolac, ibuprofen, indomethacin, flurbiprofen, fenoprofen calcium, ketoprofen, nabumetone, naproxen, naproxen sodium, piroxicam, tolmetin sodium, or sulindac

Step 2 Drug(s): celecoxib, mefenamic acid, Nalfon, Tivorbex, Zipsor



POLICY NAME:

OPIOIDS- Nucynta

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Hydromorphone, methadone, morphine, oxycodone, oxymorphone, tramadol

Step 2 Drug(s): Nucynta



POLICY NAME:

OPIOIDS (LONG-ACTING)- Exalgo, Hydromorphone ER, Hysingla ER, MS Contin, Nucynta ER, Opana ER, Oxycodone ER, Oxycontin, Zohydro ER

Effective Date: 01/01/2014

ST Policy Applicable To PDL Drug list ONLY

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug. If the patient has tried a Step 2 drug, then authorization may be given for a Step 3 drug.

Step 1 Drug(s): Fentanyl, Morphine Sulfate ER, Oxymorphone ER

Step 2 Drug(s): Hydromorphone ER, Oxycodone ER, MS Contin, Nucynta ER, Opana ER, Oxycontin

Step 3 Drug(s): Hysingla ER, Zohydro ER, Exalgo

- Authorization may be given for Exalgo, Oxycontin, or Nucynta ER if the patient has renal insufficiency.
- Authorization may be given for Oxycontin if the patient is pregnant.



POLICY NAME:

OPIOIDS (LONG-ACTING)- Hydromorphone ER, Nucynta ER, Oxycodone ER, Oxycontin

Effective Date: 01/01/2014

ST Policy Applicable To ID, OR and MT Drug List ONLY

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug.

Step 1 Drug(s): Fentanyl, Morphine Sulfate ER, Oxymorphone ER.

Step 2 Drug(s): Hydromorphone ER, Oxycodone ER, Nucynta ER, Oxycontin

- Authorization may be given for Oxycontin, or Nucynta ER if the patient has renal insufficiency.
- Authorization may be given for Oxycontin if the patient is pregnant.



POLICY NAME:
OVERACTIVE BLADDER
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Oxybutynin Chloride, Oxybutynin Chloride ER, Tolterodine, Tolterodine ER, Trospium Chloride.

Step 2 Drug(s): Darifenacin Hydrobromide ER, Gelnique, Myrbetriq, Oxytrol, Toviaz, Vesicare.

- Authorization for Oxytrol or Gelnique may be given for patients who cannot swallow or who have difficulty swallowing.



POLICY NAME:
PROTON PUMP INHIBITORS (PPI's)
Effective Date: 02/10/2016

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Lansoprazole, Omeprazole, Pantoprazole, Rabeprazole

Step 2 Drug(s): Esomeprazole

- Authorization for esomeprazole may be given in patients less than 1 year of age.



POLICY NAME:

PRESTALIA (perindopril/amlodipine)

Effective Date: 10/22/2015

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Non-formulary	Non-formulary	Non-formulary

If the patient has tried a Step 1 drug (at least a 30 day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): benazepril/amlodipine

Step 2 Drug(s): Prestalia



POLICY NAME:

PROSTAGLANDINS OPHTHALMIC –Travatan Z, Zioptan

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30 day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): generic prostaglandin analogue (latanoprost)

Step 2 Drug(s): Lumigan, Travatan Z, Zioptan



POLICY NAME:

QUDEXY XR

Effective Date: 9/1/14

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried at least a 30 day trial of Step 1 drug, then authorization may be given.

Step 1 Drug(s): topiramate

Step 2 Drug(s): Qudexy XR



POLICY NAME:

RANEXA

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): A generic nitrate plus a generic beta blocker or a generic calcium channel blocker

Step 2 Drug(s): Ranexa



POLICY NAME:

ROSACEA TOPICAL-Soolantra, Mirvaso

Effective Date: 04/15/2015

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried **TWO** Step 1 drugs (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): topical metronidazole, Finacea

Step 2 Drug(s): Soolantra, Mirvaso



POLICY NAME:

ANTI-HERPETIC AGENTS-Acyclovir ointment, Zovirax (acyclovir ointment/cream) Denavir (penciclovir cream), Sitavig (acyclovir buccal)

Effective Date: 9/1/14

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried **TWO** Step 1 drugs, then authorization may be given.

Step 1 Drug(s): Oral acyclovir, Oral famciclovir, Oral valacyclovir

Step 2 Drug(s): Sitavig, Acyclovir ointment, Zovirax ointment/cream, Denavir cream



POLICY NAME:

TOPICAL IMMUNOMODULATORS –Elidel, Protopic (topical Tacrolimus)

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given. If the patient has tried a Step 2 drug, then authorization may be given for a Step 3 drug.

Step 1 Drug(s): Aclovate, Ala-cort, Ala-scalp Hp, Alclometasone Dipropionate, Amcinonide, Betamethasone Dipropionate, Betamethasone Valerate, Carmol Hc, Clobetasol Emollient, Clobetasol Propionate, Clobex, Cloderm, Cordran tape, Cordran Sp, Cutivate, Derma-smoothe-fs, Dermatop, Desonate, Desonide, Desowen, Desoximetasone, Diprolene, Diprolene Af, Elocon, Fluocinolone Acetonide, Fluocinonide, Fluocinonide Emollient, Fluticasone Propionate, Halobetasol Propionate, Halog, Hydrocortisone, Hydrocortisone Butyrate, Hydrocortisone Valerate, Kenalog, Locoid, Locoid Lipocream, Lokara, Luxiq, Mometasone Furoate, Olux-e, Pandel, Prednicarbate, Temovate, Topicort, Topicort Lp, Triamcinolone Acetonide, Triderm, U-cort, Ultravate, Verdeso, Westcort

Step 2 Drug(s): Tacrolimus (topical)

Step 3 Drug (s): Elidel

- Authorization may be given for Tacrolimus (topical), if the patient has tried one prescription strength topical corticosteroid for atopic dermatitis or eczema in the previous 60 days.
- Authorization for Tacrolimus (topical) may be given for patients with a dermatologic condition on or around the eyes, eyelids or genitalia.
- Authorization for Tacrolimus (topical) may be given for patients with the following conditions after a trial of a prescription strength topical corticosteroid: lichen planus, seborrheic dermatitis, chronic hand dermatitis, cutaneous lupus erythematosus or dermatomyositis or discoid lupus erythematosus, psoriasis, and vitiligo.
- Authorization for Tacrolimus (topical) may be given for patients with the following conditions after a trial of a prescription strength topical corticosteroid: dyshidrotic palmar eczema, pyoderma gangrenosum, orofacial or perineal Crohn's disease, erosive pustular dermatosis, chronic cutaneous graft-vs-host disease (GVHD), chronic actinic dermatitis, allergic contact dermatitis, and bullous pemphigoid.
- Authorization may be given for Tacrolimus (topical), for steroid-induced rosacea if the patient has tried **two** therapies for rosacea (e.g., azelaic acid, topical metronidazole,



topical tretinoin products, oral antibiotics [e.g., tetracycline, metronidazole, doxycycline, minocycline, clarithromycin], or oral isotretinoin).

- Authorization may be given for Tacrolimus (topical), for severe uremic pruritus if the patient has tried **two** other therapies for this condition (e.g., emollients, capsaicin, topical corticosteroids, ultraviolet B irradiation).



POLICY NAME:

TRIPTAN AGENTS – Frovatriptan, Relpax, Zomig Nasal

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Naratriptan, Sumatriptan, Rizatriptan benzoate +ODT, Zolmitriptan +ODT, Almotriptan malate

Step 2 Drug(s): Axert, Frovatriptan, Relpax, Zomig Nasal



POLICY NAME:

ULORIC

Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Allopurinol, Probenecid, Probenecid- Colchicine

Step 2 Drug(s): Uloric