PacificSource HEALTH PLANS

2017 PacificSource Health Plans Step Therapy Criteria

Last Modified: 07/17/2017
(All criteria reviewed at least once per year)

Table of Contents

ACE-I/ARB 3

ACNE AGENTS – Acanya, Azelex 4

ACTICLATE 5

AMITIZA/LINZESS 6

ANTIDEPRESSANTS – Trintellix, Desvenlafaxine ER, Fetzima, Fluoxetine 90mg weekly, Fluvoxamine ER, Pexeva, Pristiq, Symbyax, Viibryd 7

ANTIRETROVIRAL AGENTS- Descovy, Genvoya, Odefsey 8

ATYPICAL ANTIPSYCHOTICS – Aripiprazole, Fanapt, Invega, Invega Sustenna, Latuda, Saphris, Quetiapine ER, Rexulti, Vraylar 9

BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY – Dutasteride, Dutasteride-Tamsulosin, Cardura XL, Jalyn, Rapaflo 10

BISPHOSPHONATES ORAL 11

BUTRANS 12

CALCIPOTRIENE/BETAMETHASONE TOPICALS 13

COMBINATION BETA2-AGONIST/CORTICOSTEROID INHALERS 14

DERMATOLOGICAL-WART (Veregen, Zyclara) 16

DIFICID 17

DIRECT RENIN INHIBITORS – Tekturna, Tekturna HCT 18

ECOZA (econazole 1% foam) 19

FIBRATES – Triglide 20

GABA ANALOGUES – Lyrica, Gralise, Horizant 21

INHALED CORTICOSTEROIDS- Alvesco, Flovent Diskus, Flovent HFA, Pulmicort Flexhaler 22

INSOMNIA AGENTS – Belsomra, Edluar, eszopiclone, Intermezzo, Lunesta, Rozerem, Silenor 23

Megestrol Acetate 625mg/5mL oral suspension 24

MUSCLE RELAXERS-Metaxalone tablets, Tizanidine capsules 25

NSAIDs Oral 26

OPIOIDS- Nucynta 27
OPIOIDS (LONG-ACTING)- Exalgo, Hydromorphone ER,Hysingla ER, MS Contin, Nucynta ER, Opana ER, Oxycodone ER, Oxycontin, Targiniq ER, Zohydro ER 28
OVERACTIVE BLADDER 29
PROTON PUMP INHIBITORS (PPI's) 30
PRESTALIA (perindopril/amlodipine) 31
PROSTAGLANDINS OPHTHALMIC –Travatan Z, Zioptan 32
QUDEXY XR 33
RANEXA 34
ROSACEA TOPICAL-Soolantra, Mirvaso 35
ANTI-HERPETIC AGENTS-Acyclovir ointment, Zovirax (acyclovir ointment/cream) Denavir (penciclovir cream), Sitavig (acyclovir buccal) 36
TOPICAL IMMUNOMODULATORS –Elidel, Protopic (topical Tacrolimus) 37
TRIPTAN AGENTS – Frovatriptan, Relpax, Zomig Nasal 39
ULORIC 40
ZETIA (Ezetimibe) 41

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:
ANTIRETROVIRAL AGENTS- Descovy, Genvoya, Odefsey
Effective Date: 06/22/2016

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 may be given.

Step 1 Drug(s): Truvada, Stribild, Complera

Step 2 Drug(s): Descovy, Genvoya, Odefsey

POLICY NAME:
ATYPICAL ANTIPSYCHOTICS – Aripiprazole, Fanapt, Invega, Invega Sustenna, Latuda, Saphris, 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
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 for a Step 2 drug. If a Step 2 drug has been tried, then authorization for a Step 3 drug may be given.

Step 1 Drug(s): olanzapine, quetiapine, risperidone, ziprasidone

Step 2 Drug(s): aripiprazole, Invega Sustenna, Latuda, Paliperidone ER, Zyprexa

Step 3 Drug (s): quetiapine ER, Rexulti, Vraylar, Saphris, Fanapt

- Authorization will be granted for aripiprazole without a trial of a step 1 agent, for treatment of major depressive disorder requiring adjunctive treatment with prior treatment failure with 2 antidepressants OR acute treatment of manic and mixed episodes associated with bipolar I disorder OR use in pediatric patients.
- 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%) **AND** calcipotriene 0.005%

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

POLICY NAME:
COMBINATION BETA2-AGONIST/CORTICOSTEROID INHALERS
Affected Medications: DULERA, SYMBICORT, ADVAIR 100-50 (Other strengths, non-formulary on SBDL)
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

Covered Uses:	• All FDA-approved indications not otherwise excluded by plan design. • Chronic Obstructive Pulmonary Disease (COPD)
Required Medical Information:	• For **Asthma,** documentation of current level of control per NIH guidelines (Well Controlled, Not Well Controlled, Poorly Controlled). • For **COPD**, documentation of GOLD Staging (Stage I - IV) and PFT results.

Appropriate Treatment Regimen & Other Criteria:	• **For Asthma**, failed:
	  • inhaled corticosteroid monotherapy
	  OR
	  • at least 2 other common treatments (cromolyn, leukotriene receptor antagonist, nedocromil, theophylline)
	  OR
	  • poorly controlled asthma necessitating urgent treatment with combination product.
	  • Patients with well controlled asthma for 3 months or longer, should step-down to inhaled corticosteroid monotherapy or other common treatments per National Institutes of Health (NIH) guidelines.
	• **For COPD**, failed:
	  • Long Acting Beta Agonist monotherapy
	  OR
	  • anticholingergic bronchodilator (Spiriva, Atrovent, Combivent)
	  OR
	  • poorly controlled COPD necessitating urgent treatment with combination product.

Exclusion Criteria:	• Treatment of symptoms associated with a current rhinovirus infection/cough associated with a current episode of the common cold. • Treatment of chronic cough due to GERD, NAEB, bronchiolitis, bronchiectasis, ACE-Inhibitor induced cough, whooping cough, pertussis, psychogenic cough, habit cough, tic cough.

	• Treatment of symptoms due to an acute respiratory infection (eg, bronchitis, sinusitis, pneumonia). • Coverage is not recommended for circumstances not listed in the Covered Uses.

POLICY NAME:
DERMATOLOGICAL-WART (Veregen, Zyclara)
Effective Date: 1/1/15

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): podofilox solution, imiquimod

Step 2 Drug(s): Veregen, Zyclara

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): Dificid

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:
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:
GABA ANALOGUES – Lyrica, Gralise, Horizant
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): Gabapentin, Neurontin.

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

- Members with a history of the following drugs within the 130 day look back period are excluded from step therapy for Lyrica: Seizure Medications - Diazepam, Felbamate, Ethotoin, Phenytoin, Succinimides, Primidone, Phenobarbital.
- 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:
INHALED CORTICOSTEROIDS- Alvesco, Flovent Diskus, Flovent HFA, Pulmicort Flexhaler
Effective Date: 01/01/2015

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, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Asmanex, Qvar
Step 2 Drug(s): Alvesco, flovent Diskus, Flovent HFA, Pulmicort Flexhaler

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

POLICY NAME:
MUSCLE RELAXERS-Metaxalone tablets, Tizanidine capsules
Effective Date: 1/1/15

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 may be given.

Step 1 Drug(s): baclofen, carisoprodol, cyclobenzaprine, methocarbamol, tizanidine tablets

Step 2 Drug(s): metaxalone tablets, tizanidine capsules

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, dicolofenac 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

OPIOIDS (LONG-ACTING)- Exalgo, Hydromorphone ER,Hysingla ER, MS Contin, Nucynta ER, Opana ER, Oxycodone ER, Oxycontin, Targiniq ER, Zohydro ER
Effective Date: 01/01/2014

ST Policy Applicable To PDL 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, Exalgo, **MS Contin**, Nucynta EE, **Opana ER**, Oxycontin

Step 3 Drug(s)-*PDL ONLY*: Hysingla ER, Targiniq ER, Zohydro ER

- 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:
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 lease 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

POLICY NAME:
ZETIA (Ezetimibe)
Effective Date: 03/12/2014

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 **TWO** Step 1 drugs, 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): Zetia (Ezetimibe)

- Authorization for Zetia (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 Zetia (ezetimibe) may be given if the patient has severe renal impairment (creatinine clearance of 30 mL/minute or less).

- Authorization of Zetia (ezetimibe) may be given if for management of homozygous familial sitosterolemia.

- Authorization of Zetia (ezetimibe) may be given for use in pregnant woman.

- Authorization of Zetia (ezetimibe) may be given if the patient has active liver disease or unexplained persistent elevations of serum transaminases.

- Exceptions are NOT recommended for Zetia (ezetimibe) for use in patients with moderate or severe hepatic insufficiency.

- As reviewed by a pharmacist, authorization for Zetia (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).