STEP THERAPY CRITERIA

This is a complete list of drugs that have written coverage determination policies. Drugs on this list do not indicate that this particular drug will be covered under your medical or prescription drug benefit. Please verify drug coverage by checking your formulary and member handbook. Additional restrictions and exclusions may apply. If you have questions, please contact Providence Health Plan Customer Service at 503-574-7500 or 1-800-878-4445 (TTY: 711). Service is available five days a week, Monday through Friday, between 8 a.m. and 6 p.m.

ANTIDEPRESSANTS STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY
FETZIMA, VIIBRYD

CRITERIA
REQUIRED MEDICAL INFORMATION:

Documented trial, intolerance or contraindication to two formulary, generic selective serotonin reuptake inhibitors (SSRIs), or serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., citalopram, sertraline, paroxetine, venlafaxine, duloxetine, escitalopram, fluoxetine).

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

ANTIEPILEPTIC MEDICATIONS

MEDICATION(S) SUBJECT TO STEP THERAPY

APTIOM, BANZEL, BRIVIACT 10 MG TABLET, BRIVIACT 10 MG/ML ORAL SOLN, BRIVIACT 100 MG TABLET, BRIVIACT 25 MG TABLET, BRIVIACT 50 MG TABLET, BRIVIACT 75 MG TABLET, FYCOMPA 0.5 MG/ML ORAL SUSP, FYCOMPA 10 MG TABLET, FYCOMPA 12 MG TABLET, FYCOMPA 2 MG TABLET, FYCOMPA 4 MG TABLET, FYCOMPA 6 MG TABLET, FYCOMPA 8 MG TABLET, VIMPAT 10 MG/ML SOLUTION, VIMPAT 100 MG TABLET, VIMPAT 150 MG TABLET, VIMPAT 200 MG TABLET, VIMPAT 50 MG TABLET, XCOPRI

CRITERIA

COVERED USES:

Seizure disorder

REQUIRED MEDICAL INFORMATION:

1. The patient is currently established on therapy with the requested medication (Note: starting on samples will not be considered established on therapy)
OR
2. Documentation of trial and failure of at least one formulary preferred generic antiepileptic medication (divalproex sodium, valproic acid, felbamate, lamotrigine, topiramate, carbamazepine, phenytoin, levetiracetam or clobazam)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

ANTIPSYCHOTICS - MAJOR DEPRESSIVE DISORDER

MEDICATION(S) SUBJECT TO STEP THERAPY

ABILIFY 1 MG/ML SOLUTION, ABILIFY 10 MG TABLET, ABILIFY 15 MG TABLET, ABILIFY 2 MG TABLET, ABILIFY 20 MG TABLET, ABILIFY 30 MG TABLET, ABILIFY 5 MG TABLET, ABILIFY DISCMELT, ARIPIPRAZOLE, ARIPIPRAZOLE ODT, QUETIAPINE FUMARATE, QUETIAPINE FUMARATE ER, REXULTI, SEROQUEL, SEROQUEL XR 150 MG TABLET, SEROQUEL XR 200 MG TABLET, SEROQUEL XR 300 MG TABLET, SEROQUEL XR 400 MG TABLET, SEROQUEL XR 50 MG TABLET

CRITERIA

COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

For adjunctive treatment of major depressive disorder (Rexulti®):
1.Documentation of current use of an antidepressant (e.g., citalopram, sertraline, paroxetine, duloxetine, mirtazapine, venlafaxine)
AND
2.Documented trial, failure, intolerance or contraindication to quetiapine and aripiprazole

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

ANTIPSYCHOTICS - SCHIZOPHRENIA / BIPOLAR DISORDER

MEDICATION(S) SUBJECT TO STEP THERAPY
CAPLYTA, LATUDA, REXULTI, SAPHRIS, VRAYLAR

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

For schizophrenia:
Documented trial, failure, intolerance or contraindication to two formulary, generic antipsychotics (e.g., quetiapine, olanzapine, ziprasidone, risperidone, aripiprazole).

For bipolar disorder:
Documented trial, failure, intolerance or contraindication to two formulary, generic medications for bipolar disorder (i.e., lithium, quetiapine, lamotrigine, divalproex, aripiprazole, risperidone, olanzapine).

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

QUANTITY LIMIT:

Latuda® 20 mg, 40 mg, 60 mg, 80 mg, 120 mg tablets: 1 tablet per day

AZELAIC ACID

MEDICATION(S) SUBJECT TO STEP THERAPY
AZELAIC ACID 15% GEL, AZELEX, FINACEA

CRITERIA
COVERED USES:

Commercial/Health Insurance Marketplace: All medically accepted indications not otherwise excluded from the benefit.

CRITERIA:

For Rosacea: Documented trial or contraindication to a generic topical metronidazole product

For Acne: Documented trial or contraindication to a topical antibiotic (e.g. clindamycin or erythromycin)

* Topical antibiotics should not be used alone due to risk of bacterial resistance; use in conjunction with benzoyl peroxide is recommended

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

A prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

BYSTOLIC

MEDICATION(S) SUBJECT TO STEP THERAPY
BYSTOLIC

CRITERIA

Documented trial, intolerance, or contraindication to two of the following formulary cardioselective beta-blockers: atenolol, metoprolol succinate, metoprolol tartrate, or bisoprolol

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

DIFICID

MEDICATION(S) SUBJECT TO STEP THERAPY
DIFICID

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

CRITERIA:

Documented trial or contraindication to oral vancomycin.

EXCLUSION CRITERIA: NA

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

ELIDEL

MEDICATION(S) SUBJECT TO STEP THERAPY
ELIDEL, PIMECROLIMUS

CRITERIA
COVERED USES:

All medically accepted indications not otherwise excluded from the benefit.

CRITERIA:

Documented trial or contraindication to tacrolimus 0.1% ointment or tacrolimus 0.03% ointment

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

FLECTOR

MEDICATION(S) SUBJECT TO STEP THERAPY
DICLOFENAC EPOLAMINE, FLECTOR

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

1. Trial and failure of one of the following oral NSAIDs: celecoxib, etodolac, nabumetone, meloxicam, or sulindac.
AND
2. Trial and failure of diclofenac sodium 1% topical gel (Voltaren® 1% topical gel) or diclofenac 1.5% topical solution (Pennsaid 1.5% topical solution)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

GLP-1 RECEPTOR AGONISTS

MEDICATION(S) SUBJECT TO STEP THERAPY
OZEMPIC, RYBELSUS, TRULICITY, VICTOZA 2-PAK, VICTOZA 3-PAK

CRITERIA
COVERED USES:
All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

CRITERIA:
1.Documentation of trial, contraindication or intolerance to metformin
AND
2.For exenatide (Byetta®), exenatide ER (Bydureon®), and lixisenatide (Adlyxin®): Documentation of trial, contraindication or intolerance to at least TWO (2) of the preferred glucagon-like peptide-1 (GLP-1) receptor agonists: liraglutide (Victoza®), semaglutide (Ozempic®/Rybelsus®), or dulaglutide (Trulicity®)

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:
Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

QUANTITY LIMITATIONS:
Adlyxin® = 6 mL per 28 days
Bydureon® = 4 pens per 28 days
Bydureon BCise® = 4 pens per 28 days
Byetta® = 2.4 mL per 30 days
Ozempic® 0.25 or 0.5 mg pen = 1.5 mL per 28 days
Ozempic® 1 mg pen = 3 mL per 28 days
Rybelsus® = 1 tablet per day

Trulicity® = 2 mL per 28 days
Victoza® = 9 mL per 30 days

HECTOROL / ZEMPLAR

MEDICATION(S) SUBJECT TO STEP THERAPY
DOXERCALCIFEROL 0.5 MCG CAP, DOXERCALCIFEROL 1 MCG CAPSULE, DOXERCALCIFEROL 2.5 MCG CAP, PARICALCITOL 1 MCG CAPSULE, PARICALCITOL 2 MCG CAPSULE, PARICALCITOL 4 MCG CAPSULE, ZEMPLAR 1 MCG CAPSULE, ZEMPLAR 2 MCG CAPSULE

CRITERIA
COVERED USES:

All medically accepted uses not otherwise excluded from the benefit.

CRITERIA:

Documentation of trial, intolerance, or contraindication to calcitriol

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

LAMOTRIGINE EXTENDED-RELEASE (LAMICTAL XR)

MEDICATION(S) SUBJECT TO STEP THERAPY

LAMICTAL XR, LAMICTAL XR (BLUE), LAMICTAL XR (GREEN), LAMICTAL XR (ORANGE), LAMOTRIGINE ER

CRITERIA

COVERED USES:

Seizure disorder and bipolar disorder

REQUIRED MEDICAL INFORMATION:

1. The patient is currently established on therapy with the requested medication (Note: starting on samples will not be considered established on therapy)
OR
2. Documentation of trial and failure of immediate-release lamotrigine

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

LUCEMYRA

MEDICATION(S) SUBJECT TO STEP THERAPY
LUCEMYRA

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

CRITERIA:

Patient must have tried clonidine

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale may be required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

QUANTITY LIMIT:

168 tablets every 90 days

LUMIGAN STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY
BIMATOPROST 0.03% EYE DROPS, LUMIGAN 0.01% EYE DROPS

CRITERIA
An adequate trial, contraindication, or intolerance to the use of latanoprost ophthalmic solution.

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

QUANTITY LIMIT:
2.5 ml per 25 days

NEUPRO

MEDICATION(S) SUBJECT TO STEP THERAPY
NEUPRO

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

Documented trial or contraindication to ropinirole (Requip®) AND pramipexole (Mirapex®)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

NON-PREFERRED ARBS

MEDICATION(S) SUBJECT TO STEP THERAPY
EDARBI, EDARBYCLOR

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

CRITERIA:

Documentation of trial or contraindication to two (2) generic, formulary angiotensin-receptor antagonists (ARBs) (e.g., losartan, valsartan, telmisartan, irbesartan, olmesartan, eprosartan, or candesartan).

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

OVERACTIVE BLADDER MEDICATIONS

MEDICATION(S) SUBJECT TO STEP THERAPY
DARIFENACIN ER, ENABLEX, MYRBETRIQ, SOLIFENACIN SUCCINATE, TOVIAZ, VESICARE

CRITERIA
COVERED USES:

All medically accepted indications not otherwise excluded from the benefit

CRITERIA:

Trial, intolerance, or contraindication to:
1. Oxybutynin
AND
2. Tolterodine

Note: Contraindications to anticholinergic agents include delirium, dementia/cognitive impairment, preexisting issue with chronic constipation, urinary retention, gastric retention, or uncontrolled narrow-angle glaucoma.

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

OXTELLAR XR

MEDICATION(S) SUBJECT TO STEP THERAPY
OXTELLAR XR

CRITERIA
COVERED USES:

Seizure disorder

REQUIRED MEDICAL INFORMATION:

1. Patient is currently established on therapy with the requested medication (Note: starting on samples will not be considered established on therapy)
OR
2. Documentation of trial and failure of immediate release oxcarbazepine

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

PHOSPHATE BINDERS

MEDICATION(S) SUBJECT TO STEP THERAPY
AURYXIA, FOSRENOL, LANTHANUM CARBONATE, PHOSLYRA, RENAGEL, SEVELAMER HCL, VELPHORO

CRITERIA

Documentation of trial, contraindication, or intolerance to calcium acetate tablets/capsules (Phos-Lo®) AND sevelamer carbonate tablets (Renvela®)

Or for Auryxia® to control iron deficiency anemia:
Documentation of trial and failure, contraindication, or intolerance to iron supplementation. Failure defined as failure of hemoglobin to return to normal by eight weeks of iron supplementation. Intolerance will include constipation that is not controlled by increasing fiber in diet, docusate, bulk forming laxatives (Metamucil®, Citrucel®, Benefiber®), or polyethylene glycol (Miralax®).

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

SEROTONIN ANTAGONISTS

MEDICATION(S) SUBJECT TO STEP THERAPY
ANZEMET 100 MG TABLET, ANZEMET 50 MG TABLET, SANCUSO

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

CRITERIA:

Documented trial, failure, intolerance or contraindication to ondansetron AND granisetron tablets.

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:
Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

QUANTITY LIMIT:

Anzemet®: 4 tablets per 30 days
Sancuso®: 2 patches per 30 days

SOOLANTRA STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY
IVERMECTIN 1% CREAM, SOOLANTRA

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

CRITERIA:

Documented trial, failure, intolerance or contraindication to metronidazole 0.75% topical gel, cream, or lotion

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication

QUANTITY LIMIT:

45 grams per 30 days

TRIPTAN STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY
ALMOTRIPTAN MALATE, ZOLMITRIPTAN 2.5 MG TABLET, ZOLMITRIPTAN 5 MG TABLET, ZOLMITRIPTAN ODT, ZOMIG 2.5 MG TABLET, ZOMIG 5 MG TABLET, ZOMIG ZMT

CRITERIA

Documented trial or intolerance to both of the following medications: sumatriptan, rizatriptan

EXCLUSION CRITERIA: N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication.

QUANTITY LIMIT:

Almotriptan tablets: 12 tablets per 30 days
Eletriptan tablets: 12 tablets per 30 days
Zolmitriptan tablets (2.5mg): 12 tablets per 30 days
Zolmitriptan tablets (5mg): 9 tablets per 30 days

VYZULTA STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY
VYZULTA

CRITERIA
COVERED USES:

All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

CRITERIA:

Documented trial or contraindication to latanoprost eye drops.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization may be reviewed yearly to assess continued medical necessity and effectiveness of drug.