



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

CRITERIA:

1. 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

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.

ANTIEPILEPTIC MEDICATIONS

MEDICATION(S) SUBJECT TO STEP THERAPY

APTOM, BANZEL, 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

CRITERIA:

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

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.

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.

CRITERIA:

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

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.

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.

CRITERIA:

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

For schizophrenia or bipolar disorder:

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

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:

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.

BRIVIACT

MEDICATION(S) SUBJECT TO STEP THERAPY

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

CRITERIA

COVERED USES:

Seizure disorder

CRITERIA:

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, contraindication or intolerance to levetiracetam

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

BYSTOLIC

MEDICATION(S) SUBJECT TO STEP THERAPY

BYSTOLIC

CRITERIA

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

CRITERIA:

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

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

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

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

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

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

CRITERIA:

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

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

PHOSPHATE BINDERS

MEDICATION(S) SUBJECT TO STEP THERAPY

AURYXIA, FOSRENOL, LANTHANUM CARBONATE, PHOSLYRA, RENAGEL, SEVELAMER HCL, VELPHORO

CRITERIA

COVERED USES: N/A

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.

RANEXA STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

RANEXA, RANOLAZINE ER

CRITERIA

COVERED USES:

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

CRITERIA:

Documented trial of or contraindication to a long-acting nitrate (e.g. isosorbide dinitrate, isosorbide mononitrate, or nitroglycerin patch products)

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 tablets / day

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

COVERED USES: N/A

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.