HEALTH SHARE/PROVIDENCE (OHP)

STEP THERAPY CRITERIA

Last Updated 12/01/2021

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. Prior Authorization for individual drugs and categories of drugs may be required to ensure that the drugs prescribed are indicated for conditions funded by OHP and consistent with the drug formulary. 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 503-574-8200 or 1-800-898-8174 (TTY: 711). Service is available five days a week, Monday through Friday, between 8 a.m. and 6 p.m.

ANTI-GLAUCOMA AGENTS

MEDICATION(S) SUBJECT TO STEP THERAPY

BIMATOPROST 0.03% EYE DROPS, LUMIGAN

CRITERIA

REQUIRED MEDICAL INFORMATION:

An adequate trial, contraindication, or intolerance to the use of formulary generic latanoprost 0.005% eye drops.

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

ANTIEPILEPTIC MEDICATIONS

MEDICATION(S) SUBJECT TO STEP THERAPY

APTIOM, 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, RUFINAMIDE, 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)

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.

REQUIRED MEDICAL INFORMATION:

Documented trial or contraindication to oral vancomycin.

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary and/or benefit changes.

GLP-1 RECEPTOR AGONISTS: NON-PREFERRED

MEDICATION(S) SUBJECT TO STEP THERAPY

BYDUREON BCISE, BYDUREON PEN, BYETTA

CRITERIA

COVERED USES:

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

REQUIRED MEDICAL INFORMATION:

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®)

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes.

GLP-1 RECEPTOR AGONISTS:PREFERRED- MEDICAID

MEDICATION(S) SUBJECT TO STEP THERAPY

OZEMPIC, RYBELSUS, TRULICITY, VICTOZA 2-PAK, VICTOZA 3-PAK

CRITERIA

COVERED USES:

All medically accepted indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

1. Documentation of trial (at least three (3) months of treatment), 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®)

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes.

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

CRITERIA

COVERED USES:

All medically accepted uses not otherwise excluded from the benefit.

CRITERIA:

Documentation of trial, intolerance, or contraindication to calcitriol

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.

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes.

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.

REQUIRED MEDICAL INFORMATION:

Patient must have tried clonidine

COVERAGE DURATION:

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

ONGENTYS

MEDICATION(S) SUBJECT TO STEP THERAPY

ONGENTYS

CRITERIA

COVERED USES:

All medically accepted indications.

REQUIRED MEDICAL INFORMATION:

Documented trial, intolerance, or contraindication to generic entacapone

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

OVERACTIVE BLADDER MEDICATIONS

MEDICATION(S) SUBJECT TO STEP THERAPY

DARIFENACIN ER, GEMTESA, MYRBETRIQ, TOVIAZ

CRITERIA

COVERED USES:

All medically accepted indications not otherwise excluded from the benefit

REQUIRED MEDICAL INFORMATION:

Trial, intolerance, or contraindication to:

1. One of the following: oxybutynin or tolterodine,

AND

2. Solifenacin

OR

For Myrbetriq: Treatment of neurogenic detrusor overactivity (NDO) in pediatric patients three years and older and weighing 35 kilograms or more

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

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

PHOSPHATE BINDERS

MEDICATION(S) SUBJECT TO STEP THERAPY

AURYXIA, FOSRENOL 1,000 MG POWDER PACK, FOSRENOL 750 MG POWDER PACKET, LANTHANUM CARBONATE, SEVELAMER HCL

CRITERIA

COVERED USES:

All medically accepted indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

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

For Auryxia® to control iron deficiency anemia:

Documentation of trial and failure, contraindication, or intolerance to iron supplementation. Failure is 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

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

TRELEGY ELLIPTA

MEDICATION(S) SUBJECT TO STEP THERAPY
TRELEGY ELLIPTA

CRITERIA
COVERED USES:
All medically accepted indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:
1. Documented 60-day trial of dual therapy with a formulary combination of a long-acting muscarinic antagonist and long-acting beta agonist (LAMA and LABA), long-acting beta agonist and inhaled corticosteroid (LABA and ICS) or a long-acting muscarinic antagonist and inhaled corticosteroid (LAMA and ICS)

COVERAGE DURATION:
Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

TRIPTAN STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

ZOLMITRIPTAN 2.5 MG TABLET, ZOLMITRIPTAN 5 MG TABLET, ZOLMITRIPTAN ODT

CRITERIA

REQUIRED MEDICAL INFORMATION:

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

COVERAGE DURATION:

Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes