STEP THERAPY CRITERIA

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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.

ANTI-GLAUCOMA AGENTS

MEDICATION(S) SUBJECT TO STEP THERAPY

BIMATOPROST 0.03% EYE DROPS, LUMIGAN, VYZULTA, ZIOPTAN

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

ANTIDEPRESSANTS STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

FETZIMA, TRINTELLIX, 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). Examples of formulary SSRI or SNRI's include but are not limited to the following: citalopram, sertraline, paroxetine, venlafaxine, duloxetine, escitalopram, and fluoxetine.

COVERAGE DURATION:

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

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, 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)

ANTIPSYCHOTICS: MAJOR DEPRESSIVE DISORDER

MEDICATION(S) SUBJECT TO STEP THERAPY
REXULTI

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

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

ASENAPINE MALEATE, CAPLYTA, LATUDA, REXULTI, SAPHRIS, SECUADO, VRAYLAR

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

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 (e.g., lithium, quetiapine, lamotrigine, divalproex, aripiprazole, risperidone, olanzapine, ziprasidone).

COVERAGE DURATION:

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

BYSTOLIC

MEDICATION(S) SUBJECT TO STEP THERAPY

BYSTOLIC, NEBIVOLOL HCL

CRITERIA

COVERED USES:

All medically accepted indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

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

COVERAGE DURATION:

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

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.

ELIDEL

MEDICATION(S) SUBJECT TO STEP THERAPY

ELIDEL, PIMECROLIMUS

CRITERIA

COVERED USES:

All medically accepted indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

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

COVERAGE DURATION:

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

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)

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

GLP-1 RECEPTOR AGONISTS: PREFERRED

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.

REQUIRED MEDICAL INFORMATION:

1. One (1) of the following:

a. History of use of a medication containing metformin within the previous 180 days (verified by pharmacy claims), or

b. Documentation of trial, intolerance, or contraindication 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, 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

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
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

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®)

COVERAGE DURATION:

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

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, ENABLEX, 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

OR

For Toviaz: Treatment of neurogenic detrusor overactivity (NDO) in pediatric patients six years and older and weighing 25 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, LANTHANUM CARBONATE, PHOSLYRA, RENAGEL, SEVELAMER HCL, VELPHORO

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®).

COVERAGE DURATION:

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

SEROTONIN ANTAGONISTS

MEDICATION(S) SUBJECT TO STEP THERAPY

SANCUSO

CRITERIA

COVERED USES:

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

REQUIRED MEDICAL INFORMATION:

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

COVERAGE DURATION:

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

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.

REQUIRED MEDICAL INFORMATION:

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

COVERAGE DURATION:

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

TOPICAL ANTIBIOTICS

MEDICATION(S) SUBJECT TO STEP THERAPY

ALTABAX, XEPI

CRITERIA

COVERED USES:

All medically accepted indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

Documented trial and failure, intolerance or contraindication to mupirocin 2% ointment

COVERAGE DURATION:

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

TRIPTAN STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

ALMOTRIPTAN MALATE, ELETRIPTAN HBR, RELPAX, ZOLMITRIPTAN 2.5 MG NASAL SPRY, ZOLMITRIPTAN 2.5 MG TABLET, ZOLMITRIPTAN 5 MG NASAL SPRAY, ZOLMITRIPTAN 5 MG TABLET, ZOLMITRIPTAN ODT, ZOMIG, ZOMIG ZMT

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