Providence Health Plan

STEP THERAPY CRITERIA

Last Updated: 10/02/2023

This document contains clinical criteria for coverage of certain drugs that may be covered under your pharmacy benefit. This document is accurate as of the last update date and is subject to change.

Please note that additional restrictions and exclusions to drug coverage may apply. You can search for your drugs on the "Drug Search" online tool for your formulary found at:
https://www.providencehealthplan.com/members/pharmacy-resources

ANTI-GLAUCOMA AGENTS

MEDICATION(S) SUBJECT TO STEP THERAPY

BIMATOPROST 0.03% EYE DROPS, LUMIGAN, RHOPRESSA, TAFLUPROST, 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

MEDICATION(S) SUBJECT TO STEP THERAPY

FETZIMA, TRINTELLIX

CRITERIA

REQUIRED MEDICAL INFORMATION:

1. The patient is currently established on therapy with the requested medication (Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are NOT considered established on therapy) OR
2. Documented trial, intolerance, or contraindication to one formulary generic antidepressant, including selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), bupropion, or mirtazapine. 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 of at least one formulary preferred generic antiepileptic medication (divalproex sodium, valproic acid, felbamate, lamotrigine, topiramate, carbamazepine, phenytoin, levetiracetam or clobazam)

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

GIP/GLP-1 RECEPTOR AGONISTS:NON-PREFERRED

MEDICATION(S) SUBJECT TO STEP THERAPY

MOUNJARO

CRITERIA

COVERED USES:

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

REQUIRED MEDICAL INFORMATION:

For initial authorization, all the following criteria are required:

1. Diagnosis of type 2 diabetes mellitus

AND

2. One of the following:

a. Inadequate response to a 90-day trial, intolerance or contraindication to metformin

b. Patient has documentation of atherosclerotic cardiovascular disease, or is at high risk of atherosclerotic cardiovascular disease (defined as age greater than 55 and two additional risk factors including obesity, hypertension, smoking, dyslipidemia, or albuminuria)

AND

3. For non-preferred GIP/GLP-1 receptor agonists [exenatide (Byetta®), exenatide ER (Bydureon®), and lixisenatide (Adlyxin®)]: Inadequate response (after at least 90-days of therapy), contraindication, or intolerance to at least TWO preferred agents: liraglutide (Victoza®), semaglutide (Ozempic®/Rybelsus®), dulaglutide (Trulicity®), or tirzepatide (Mounjaro®)

COVERAGE DURATION:

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

GIP/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:

For initial authorization, all the following criteria are required:

1. Diagnosis of type 2 diabetes mellitus

AND

2. One of the following:

a. Inadequate response to a 90-day trial, intolerance or contraindication to metformin

b. Patient has documentation of atherosclerotic cardiovascular disease, or is at high risk of atherosclerotic cardiovascular disease (defined as age greater than 55 and two additional risk factors including obesity, hypertension, smoking, dyslipidemia, or albuminuria)

AND

3. For non-preferred GIP/GLP-1 receptor agonists [exenatide (Byetta®), exenatide ER (Bydureon®), and lixisenatide (Adlyxin®)]: Inadequate response (after at least 90-days of therapy), contraindication, or intolerance to at least TWO preferred agents: liraglutide (Victoza®), semaglutide (Ozempic®/Rybelsus®), dulaglutide (Trulicity®), or tirzepatide (Mounjaro®)

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
MYRBETRIQ

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

REQUIRED MEDICAL INFORMATION:
One of the following must be met:
1. Trial, intolerance, or contraindication to one of the following:
a. oxybutynin
b. tolterodine
c. solifenacin
d. darifenacin
e. trospium
2. Use is for 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. Additional contraindications include contraindications listed on respective medication package inserts.

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, RENVELA 0.8 GM POWDER PACKET, RENVELA 2.4 GM POWDER PACKET, SEVELAMER 0.8 GM POWDER PACKET, SEVELAMER 2.4 GM POWDER PACKET, 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

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 topical gel, cream, or lotion

COVERAGE DURATION:

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

QUANTITY LIMIT:

45 grams per 30 days

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

ZYFLO

MEDICATION(S) SUBJECT TO STEP THERAPY
ZILEUTON ER

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

REQUIRED MEDICAL INFORMATION:
Trial, intolerance, or contraindication to montelukast and zafirlukast

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