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

VIIBRYD

CRITERIA

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).

ANTIEPILEPTIC MEDICATIONS

MEDICATION(S) SUBJECT TO STEP THERAPY

APTIOM, BANZEL, VIMPAT 10 MG/ML SOLUTION, VIMPAT 100 MG TABLET, VIMPAT 150 MG TABLET, VIMPAT 200 MG TABLET, VIMPAT 50 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 of at least one formulary antiepileptic medication

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:

Clobazam tablets and films: 2 tablets/films per day

Clobazam oral suspension: 16 mL/day

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

QUANTITY LIMIT:

Oral tablets: 2 tablets per day

Oral solution: 20 mL/day

BYSTOLIC, BYVALSON

MEDICATION(S) SUBJECT TO STEP THERAPY

BYSTOLIC

CRITERIA

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

ELIDEL

MEDICATION(S) SUBJECT TO STEP THERAPY

ELIDEL, PIMECROLIMUS

CRITERIA

Documented trial or contraindication to tacrolimus 0.1% ointment or tacrolimus 0.3% ointment.

FINACEA

MEDICATION(S) SUBJECT TO STEP THERAPY

AZELAIC ACID 15% GEL, FINACEA

CRITERIA

Documented trial or contraindication to a generic topical metronidazole product.

FLECTOR

MEDICATION(S) SUBJECT TO STEP THERAPY

DICLOFENAC EPOLAMINE, FLECTOR

CRITERIA

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).

GLP-1 RECEPTOR AGONISTS

MEDICATION(S) SUBJECT TO STEP THERAPY
OZEMPIC, 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®), albiglutide (Tanzeum®) and lixisenatid (Adlyxin®):
   documentation of trial, contraindication or intolerance to at least TWO of the preferred glucagon-like peptide-1 (GLP-1) receptor agonistsliraglutide (Victoza®), semaglutide (Ozempic®), 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
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

Tanzeum® = 4 pens per 28 days
Trulicity® = 2 mL per 28 days
Victoza® = 9 mL per 30 days

HECTORAL/ZEMPLAR

MEDICATION(S) SUBJECT TO STEP THERAPY

DOXERCALCIFEROL 0.5 MCG CAP, DOXERCALCIFEROL 1 MCG CAPSULE, DOXERCALCIFEROL 2.5 MCG CAP, HECTOROL 0.5 MCG CAPSULE, HECTOROL 1 MCG CAPSULE, HECTOROL 2.5 MCG CAPSULE, PARICALCITOL 1 MCG CAPSULE, PARICALCITOL 2 MCG CAPSULE, PARICALCITOL 4 MCG CAPSULE, ZEMPLAR 1 MCG CAPSULE, ZEMPLAR 2 MCG CAPSULE

CRITERIA

Documentation of trial, intolerance, or contraindication to calcitriol.

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

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

Patient must have tried clonidine immediate release tablets or transdermal patches

LUMIGAN STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

BIMATOPROST 0.03% EYE DROPS, LUMIGAN

CRITERIA

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

QUANTITY LIMIT:

2.5 ml per 25 days

NON-PREFERRED ARBS

MEDICATION(S) SUBJECT TO STEP THERAPY

EDARBI, EDARBYCLOR

CRITERIA

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

OVERACTIVE BLADDER MEDICATIONS

MEDICATION(S) SUBJECT TO STEP THERAPY

DARIFENACIN ER, ENABLEX, MYRBETRIQ, 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: Contraindication to anticholinergics can include delirium, dementia/cognitive impairment, preexisting issue with chronic constipation, urinary retention, gastric retention, or uncontrolled narrow-angle glaucoma.

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: NA

PRESCRIBER RESTRICTIONS: NA

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

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®).

RANEXA STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

RANEXA, RANOLAZINE ER

CRITERIA

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

SEROTONIN ANTAGONISTS

MEDICATION(S) SUBJECT TO STEP THERAPY

ANZEMET, SANCUSO

CRITERIA

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

SOOLANTRA STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY
SOOLANTRA

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

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

TRIPTAN STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

ALMOTRIPTAN MALATE, AXERT, ELETRIPTAN HBR, RELPAX, 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.

VYZULTA STEP THERAPY

MEDICATION(S) SUBJECT TO STEP THERAPY

VYZULTA

CRITERIA

Documented trial or contraindication to latanaprost eye drops