



## 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

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## MEDICATION(S) SUBJECT TO STEP THERAPY

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

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## **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

## **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 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.

## **ANTIPSYCHOTICS - MAJOR DEPRESSIVE DISORDER**

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### **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

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### **MEDICATION(S) SUBJECT TO STEP THERAPY**

LATUDA, REXULTI, SAPHRIS, VRAYLAR

### **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 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

# BRIVIACT

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## **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, BYVALSON**

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### **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

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## **MEDICATION(S) SUBJECT TO STEP THERAPY**

ELIDEL, PIMECROLIMUS

## **CRITERIA**

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



# FINACEA

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## **MEDICATION(S) SUBJECT TO STEP THERAPY**

AZELAIC ACID 15% GEL, FINACEA

## **CRITERIA**

Documented trial or contraindication to a generic topical metronidazole product.

# FLECTOR

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## **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

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## 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 lixisenatide (Adlyxin®): documentation of trial, contraindication or intolerance to at least TWO of the preferred glucagon-like peptide-1 (GLP-1) receptor agonists liraglutide (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

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### **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)

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### **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

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## **MEDICATION(S) SUBJECT TO STEP THERAPY**

LUCEMYRA

## **CRITERIA**

Patient must have tried clonidine immediate release tablets or transdermal patches

# LUMIGAN STEP THERAPY

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## **MEDICATION(S) SUBJECT TO STEP THERAPY**

BIMATOPROST 0.03% EYE DROPS, LUMIGAN 0.01% EYE DROPS

## **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**

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### **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

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## 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: 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**

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## **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

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### **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**

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### **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

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### **MEDICATION(S) SUBJECT TO STEP THERAPY**

ANZEMET 100 MG TABLET, ANZEMET 50 MG TABLET, SANCUSO

### **CRITERIA**

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

## **SOOLANTRA STEP THERAPY**

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### **MEDICATION(S) SUBJECT TO STEP THERAPY**

IVERMECTIN 1% CREAM, 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**

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### **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

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## **MEDICATION(S) SUBJECT TO STEP THERAPY**

VYZULTA

## **CRITERIA**

Documented trial or contraindication to latanaprost eye drops