

Step Therapy Criteria

Step Therapy Group ABILIFY ODT
Drug Names ABILIFY DISCMELT
Step Therapy Criteria PATIENT MUST FILL A 30 DAY SUPPLY OF ABILIFY TABS WITHIN THE PAST 180 DAYS

Step Therapy Group ALPHA ADRENERGICS
Drug Names UROXATRAL
Step Therapy Criteria PATIENT MUST FILL A 30 DAY SUPPLY OF TAMSULOSIN WITHIN THE PAST 180 DAYS

Step Therapy Group ALPHA REDUCTASE
Drug Names AVODART
Step Therapy Criteria PATIENT MUST FILL A 60 DAY SUPPLY OF FINASTERIDE WITHIN THE LAST 180 DAYS

Step Therapy Group ANTICHOLINERGIC
Drug Names DETROL, DETROL LA, SANCTURA XR
Step Therapy Criteria PATIENT MUST FILL 30 DAY SUPPLY OF OXYBUTYNIN WITHIN THE LAST 180 DAYS

Step Therapy Group ANTICOAGULANTS
Drug Names PRADAXA
Step Therapy Criteria PREVIOUS USE OF WARFARIN HAS BEEN INEFFECTIVE, NOT TOLERATED OR IS CONTRAINDICATED

Step Therapy Group ARB
Drug Names ATACAND, ATACAND HCT, AVALIDE, AVAPRO, DIOVAN, DIOVAN HCT, MICARDIS, MICARDIS HCT, TEKTRUNA, TEKTRUNA HCT
Step Therapy Criteria PATIENT MUST FILL A 60 DAY SUPPLY OF LOSARTAN AND BENICAR WITHIN THE PAST 180 DAYS

Step Therapy Group BETA BLOCKER
Drug Names LEVATOL
Step Therapy Criteria PATIENT MUST FILL A 30 DAY SUPPLY OF TWO OF THE FOLLOWING:
ATENOLOL, BISPPROLOL, CARVEDILOL, LABETALOL, METOPROLOL, NADOLOL, PINDOLOL, PROPRANOLOL, SOTALOL, TIMOLOL WITHIN THE PAST 120 DAYS

<i>Step Therapy Group</i>	CALCIUM CHANNEL
<i>Drug Names</i>	DYNACIRC CR
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 30 DAY SUPPLY OF TWO OF THE FOLLOWING: AMLODIPINE, DILTIAZEM, FELODIPINE, ISRADIPINE, NIFEDIPINE, VERAPAMIL WITHIN THE PAST 120 DAYS
<i>Step Therapy Group</i>	CARBONIC ANHYDRASE
<i>Drug Names</i>	AZOPT
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 60 DAY SUPPLY OF DORZOLAMIDE WITHIN THE LAST 180 DAYS
<i>Step Therapy Group</i>	CHOLINESTERASE
<i>Drug Names</i>	ARICEPT, ARICEPT ODT, EXELON
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 30 DAY SUPPLY OF GALANTAMINE WITHIN THE LAST 180 DAYS.
<i>Step Therapy Group</i>	DIABETIC
<i>Drug Names</i>	ACTOPLUS MET, ACTOPLUS MET XR, ACTOS, AVANDAMET, AVANDARYL, AVANDIA, DUETACT, JANUMET, JANUVIA, ONGLYZA
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 90 DAY SUPPLY OF METFORMIN WITHIN THE PAST 120 DAYS
<i>Step Therapy Group</i>	ELIDEL
<i>Drug Names</i>	ELIDEL
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 30 DAY SUPPLY OF ONE GENERIC TOPICAL STEROID (BETAMETHASONE, CLOBETASOL, DESONIDE, FLUOCINONIDE, HYDROCORTISONE, MOMETASONE, TRIAMCINOLONE) WITHIN THE PAST 120 DAYS
<i>Step Therapy Group</i>	FENOFIBRATE
<i>Drug Names</i>	TRICOR
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 60 DAY SUPPLY OF FENOFIBRATE WITHIN THE PAST 120 DAYS
<i>Step Therapy Group</i>	HYPNOTICS
<i>Drug Names</i>	LUNESTA
<i>Step Therapy Criteria</i>	PATIENT MUST HAVE A 30 DAY SUPPLY OF BOTH ZALEPLON AND ZOLPIDEM WITHIN THE PAST 120 DAYS

<i>Step Therapy Group</i>	INHALED CORTICOSTEROID
<i>Drug Names</i>	ASMANEX 120 METERED DOSES, ASMANEX 14 METERED DOSES, ASMANEX 30 METERED DOSES, ASMANEX 60 METERED DOSES, FLOVENT DISKUS, FLOVENT HFA
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 30 DAY SUPPLY OF QVAR AND PULMICORT WITHIN THE PAST 180 DAYS
<i>Step Therapy Group</i>	KEPPRA XR
<i>Drug Names</i>	KEPPRA XR
<i>Step Therapy Criteria</i>	PATIENT MUST HAVE FILLED A 60 DAYS SUPPLY OF LEVETIRACETAM WITHIN THE PAST 120 DAYS
<i>Step Therapy Group</i>	LATUDA
<i>Drug Names</i>	LATUDA
<i>Step Therapy Criteria</i>	PREVIOUS USE OF RISPERIDONE, SEROQUEL, GEODON OR ZYPREXA HAS BEEN INEFFECTIVE, NOT TOLERATED OR IS CONTRAINDICATED
<i>Step Therapy Group</i>	OMEGA-3
<i>Drug Names</i>	LOVAZA
<i>Step Therapy Criteria</i>	PATIENT MUST HAVE FILLED A 60 DAY SUPPLY OF A GENERIC STATIN (LOVASTATIN, PRAVASTATIN, SIMVASTATIN) AND GEMFIBROZIL OR GENERIC FENOFIBRATE WITHIN THE PAST 120 DAYS
<i>Step Therapy Group</i>	OPHTHALMIC PROSTAGLANDINS
<i>Drug Names</i>	XALATAN
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 30 DAY SUPPLY OF BOTH LUMIGAN AND TRAVATAN WITHIN THE PAST 180 DAYS
<i>Step Therapy Group</i>	PROTON PUMP INHIBITORS
<i>Drug Names</i>	ACIPHEX, NEXIUM
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 30 DAY SUPPLY OF OMEPRAZOLE AND PANTOPRAZOLE OR LANSOPRAZOLE WITHIN THE LAST 120 DAYS.
<i>Step Therapy Group</i>	SNRI
<i>Drug Names</i>	PRISTIQ
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 30 DAY SUPPLY OF VENLAFAXINE XR TABLS WITHIN THE PAST 180 DAYS

<i>Step Therapy Group</i>	SSRI'S
<i>Drug Names</i>	LEXAPRO, PAXIL CR
<i>Step Therapy Criteria</i>	PATIENT MUST FILL 30 DAY SUPPLY OF TWO OR MORE GENERIC SSRIS (CITALOPRAM, FLUOXETINE, FLUVOXAMINE, PAROXETINE, PAROXETINE CR, SERTRALINE) WITHIN THE PAST 180 DAYS
<i>Step Therapy Group</i>	STATINS
<i>Drug Names</i>	CRESTOR, LESCOL, LESCOL XL, LIPITOR
<i>Step Therapy Criteria</i>	PATIENT MUST FILL 60 DAY SUPPLY OF A GENERIC STATIN AND PATIENT MUST FILL 60 DAY SUPPLY OF VYTORIN WITHIN THE LAST 180 DAYS
<i>Step Therapy Group</i>	STAVZOR
<i>Drug Names</i>	STAVZOR
<i>Step Therapy Criteria</i>	PATIENT MUST HAVE FILLED A 60 DAYS SUPPLY OF DIVALPROEX, DIVALPROEX ER, OR VALPROIC ACID WITHIN 120 DAYS
<i>Step Therapy Group</i>	TEGRETOL XR
<i>Drug Names</i>	TEGRETOL-XR
<i>Step Therapy Criteria</i>	PATIENT MUST FILL A 60 DAY SUPPLY OF TWO OR MORE OF THE FOLLOWING (CARBAMAZEPINE, DIVALPROEX, PHENYTOIN, LEVETIRACETAM, LAMOTRIGINE, VALPROIC ACID) WITHIN THE LAST 120 DAYS
<i>Step Therapy Group</i>	TRIPTAN
<i>Drug Names</i>	MAXALT, MAXALT-MLT, RELPAX, ZOMIG, ZOMIG ZMT
<i>Step Therapy Criteria</i>	PATIENT MUST HAVE FILLED A 10 DAY SUPPLY OF SUMATRIPTAN WITHIN THE PAST 120 DAYS
<i>Step Therapy Group</i>	VIIBRYD
<i>Drug Names</i>	VIIBRYD
<i>Step Therapy Criteria</i>	PREVIOUS USE OF 2 OR MORE ANTIDEPRESSANTS HAVE BEEN INEFFECTIVE, NOT TOLERATED OR CONTRAINDICATED
<i>Step Therapy Group</i>	XIFAXAN
<i>Drug Names</i>	XIFAXAN
<i>Step Therapy Criteria</i>	PREVIOUS USE OF LACTULOSE WAS INEFFECTIVE, NOT TOLERATED OR IS CONTRAINDICATED

Step Therapy Group
Drug Names
Step Therapy Criteria

ZMAX

ZMAX

PATIENT MUST FILL A 10 DAY SUPPLY OF TWO OR MORE OF THE FOLLOWING (AZITHROMYCIN, ERYTHROMYCIN, CLARITHROMYCIN) WITHIN THE PAST 120 DAYS