2018-2019 PacificSource Health Plans Step Therapy Criteria

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(All criteria reviewed at least once per year)

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POLICY NAME:
ACNE AGENTS – Acanya, Azelex
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs, then authorization for a drug in Step 2 drug may be given.

Step 1 Drug(s): benzoyl peroxide, clindamycin topical, clindamycin/benzoyl peroxide, erythromycin topical, erythromycin/benzoyl peroxide, sodium sulfacetamide, or sodium sulfacetamide/sulfur.

Step 2 Drug(s): Acanya, Azelex

POLICY NAME:
ACTICLATE
Effective Date: 01/01/2015

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried a Step 1 drug at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Doxycycline tablets

Step 2 Drug(s): Acticlate

POLICY NAME:
AMITIZA/LINZESS
Effective Date: 05/15/2015

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried one Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Enulose, Lactulose, Polyethylene Glycol 3350

Step 2 Drug(s): Amitiza, Linzess

POLICY NAME:
ANTIDEPRESSANTS – Fetzima, fluoxetine 90mg (weekly), fluvoxamine ER, olanzapine-fluoxetine, Viibryd, Trintellix, Pexeva
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs, then authorization for a drug in Step 2 drug may be given.

Step 1 Drug(s):
Preferred and ID/OR/MT Drug Lists: bupropion, bupropion SR (12-hour), bupropion XL (24-hour), citalopram, desvenlafaxine extended release (ER), escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine ER, sertraline, venlafaxine, venlafaxine ER capsule
Preferred Drug List only: Wellbutrin, Wellbutrin SR, Wellbutrin XL, Celexa, Lexapro, Prozac, Paxil, Paxil CR, Zoloft, Effexor, Effexor XR capsules

Step 2 Drug(s):
Preferred and ID/OR/MT Drug Lists: fluoxetine 90mg (weekly), fluvoxamine ER, Viibryd, Pexeva
Preferred Drug List only: Prozac weekly, Fetzima, olanzapine-fluoxetine, Trintellix

- This step therapy program applies to new utilizers only

POLICY NAME:
ATYPICAL ANTIPSYCHOTICS – Fanapt, Invega Sustenna, Latuda, Saphris, Paliperidone ER, Quetiapine ER, Rexulti, Vraylar
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug.

Step 1 Drug(s): Aripiprazole, Olanzapine, Quetiapine, Risperidone, Ziprasidone

Step 2 Drug(s): Fanapt, Invega Sustenna, Latuda, Paliperidone ER, Quetiapine ER, Vraylar

Step 3 Drug(s): Rexulti

- Authorization will be granted for Latuda without a trial of a step 1 agent, for treatment of bipolar depression.

POLICY NAME:
ATYPICAL ANTIPSYCHOTICS – Fanapt, Invega Sustenna, Invega ER, Latuda, Paliperidone ER, Quetiapine ER, Rexulti, Saphris, Seroquel XR, Vraylar
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug.

Step 1 Drug(s): Abilify, Aripiprazole, Geodon, Olanzapine, Quetiapine, Risperidone, Risperdal, Seroquel, Ziprasidone, Zyprexa

Step 2 Drug(s): Fanapt, Invega Sustenna, Invega ER, Latuda, Paliperidone ER, Quetiapine ER, Seroquel XR, Saphris, Vraylar

Step 3 Drug(s): Rexulti

- Authorization will be granted for Latuda without a trial of a step 1 agent, for treatment of bipolar depression.

POLICY NAME:
BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY – Dutasteride, Dutasteride-Tamsulosin, Cardura XL, Jalyn, Rapaflo
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried one Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): finasteride, dutasteride, terazosin

Step 2 Drug(s): dutasteride-tamsulosin, Jalyn, Cardura XL, Rapaflo

POLICY NAME:
BISPHOSPHONATES ORAL
Effective Date: 06/13/2018

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes (Fosamax+D Non-form)	Yes (Fosamax+D Non-form)	Yes (Fosamax+D Non-form)

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Alendronate Sodium, Ibandronate Sodium Tab 150 MG

Step 2 Drug(s): Risedronate Sodium, Risedronate Sodium DR, Fosamax+D

- Authorization may be given for Risedronate for use in the management of Paget's disease if the patient has started therapy with Risedronate

POLICY NAME:
BUTRANS
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

Coverage will be provided if **TWO** Step 1 drugs have been tried within the last 180 days, or there is documented rationale for avoidance, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): acetaminophen/codeine, acetaminophen/codeine #2, acetaminophen/codeine #3, acetaminophen/codeine #4, Endocet, hydrocodone/acetaminophen, hydrocodone/ibuprofen, oxycodone/acetaminophen, oxycodone/aspirin, Reprexain, tramadol, tramadol ER, tramadol ER (biphasic), tramadol/acetaminophen

Step 2 Drug(s): Butrans patch

POLICY NAME:
CALCIPOTRIENE/BETAMETHASONE TOPICALS
Effective Date: 12/01/14

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): high potency topical corticosteroid (such as betamethasone dipropionate 0.05%) **OR** calcipotriene 0.005%

Step 2 Drug(s): Taclonex suspension, Enstilar Foam

POLICY NAME:
DIFICID & VANCOMYCIN
Effective Date: 05/15/2015

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Firvanq for oral suspension

Step 2 Drug(s): Dificid, Vancomycin capsules

POLICY NAME:
DIRECT RENIN INHIBITORS – Tekturna, Tekturna HCT
Effective Date: 09/14/2016

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs, then authorization may be given.

Step 1 Drug(s):
Amlodipine Besylate-benazepril, Atacand, Atacand Hct, Azor, Benazepril Hcl, Benazepril-hydrochlorothiazide, Benicar, Benicar Hct, Captopril, Captopril-hydrochlorothiazide, Candesartan, Candesartan-hydrochlorothiazide, Cozaar, Diovan, Diovan Hct, Edarbi, Enalapril Maleate, Enalapril-hydrochlorothiazide, eprosartan, Exforge, Exforge Hct, Fosinopril Sodium, Fosinopril-hydrochlorothiazide, Lisinopril, Lisinopril-hydrochlorothiazide, Losartan Potassium, Losartan-Hydrochlorothiazide, Lotensin, Lotensin Hct, Micardis, Micardis Hct, Moexipril Hcl, Moexipril-hydrochlorothiazide, Perinopril erbumine, Quinapril Hcl, Quinapril-hydrochlorothiazide, Ramipril, Tarka, Telmisartan, Telmisartan-Amlodipine, Teveten, Teveten Hct, Trandolapril,Tribenzor, Twynsta, Vasotec.

Step 2 Drug(s): Tekturna, Tekturna HCT

POLICY NAME:
ECOZA (econazole 1% foam)
Effective Date: 05/14/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried one Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): econazole 1% cream

Step 2 Drug(s): Ecoza

- Authorization for Ecoza may be given if the patient has a generic econazole claim within the last 180 days

POLICY NAME:
ENDARI (L-glutamine)
Effective Date: 10/11/2017

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried one Step 1 drug, (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Hydroxyurea

Step 2 Drug(s): Endari

POLICY NAME:
EZETIMIBE, EZETIMIBE-SIMVASTATIN
Effective Date: 06/13/2018

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried ONE Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Atorvastatin, Rosuvastatin, Fluvastatin, Lovastatin, Pravastatin Sodium, Simvastatin

Step 2 Drug(s): Ezetimibe, Ezetimibe-Simvastatin

- Authorization for Ezetimibe may be given if the patient is taking or will be taking a medication that has a significant drug interaction with any of the HMG-CoA reductase inhibitors [statins] (eg, cyclosporine, fibrates, niacin more than 1 g/day, itraconazole, ketoconazole, erythromycin, clarithromycin, HIV protease inhibitors, nefazodone, amiodarone, and verapamil).

- Authorization of Ezetimibe may be given if the patient has severe renal impairment (creatinine clearance of 30 mL/minute or less).

- Authorization of Ezetimibe may be given if for management of homozygous familial sitosterolemia.

- Authorization of Ezetimibe may be given for use in pregnant woman.

- Authorization of Ezetimibe may be given if the patient has active liver disease or unexplained persistent elevations of serum transaminases.

- Exceptions are NOT recommended for Ezetimibe for use in patients with moderate or severe hepatic insufficiency.

- As reviewed by a pharmacist, authorization for Ezetimibe may be given for use in patients who have been previously diagnosed with myopathy or rhabdomyolysis (either medication-related or not medication related) OR the patient has an underlying muscle/muscle-metabolism-related disorder (eg, myositis, McArdle disease).

POLICY NAME:
FIBRATES – Triglide
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): At least a 30 day supply of a generic fibrate within the past 365 days.

Step 2 Drug(s): Triglide

POLICY NAME:
GLUCAGON-LIKE PEPTIDE-1 AGONISTS – Victoza, Trulicity, Ozempic
Effective Date: 03/22/2018

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 90-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Metformin

Step 2 Drug(s): Victoza, Trulicity, Ozempic

- Patients with renal disease or renal dysfunction (eGFR less than 30) may be approved

POLICY NAME:
INSOMNIA AGENTS – Belsomra, Edluar, eszopiclone, Intermezzo, Lunesta, Rozerem, Silenor
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes (except Rozerem, Silenor)	Rozerem only (others are non-formulary)	Rozerem only (others are non-formulary)	Rozerem only (others are non-formulary)

If the patient has triedn **TWO Step 1 drugs**, then authorization for a Step 2 drug may be given. If the patient has tried **TWO step 2 drugs**, then authorization for a Step 3 drug may be given.

Step 1 Drugs: At least a 30 day supply of a generic hypnotic (eszopiclone,zolpidem, zaleplon, temazepam, triazolam, ect.) within the past 180 days.

Step 2 Drugs: At lease a 30 day supply of the following Edluar, Intermezzo, Lunesta brand, Rozerem, Silenor.

Step 3 Drugs: Belsomra

POLICY NAME:
Megestrol Acetate 625mg/5mL oral suspension
Effective Date: 03/15/2015

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): megestrol acetate 40mg/ml oral suspension

Step 2 Drug(s): megestrol acetate 625mg/5mL oral suspension, Megace ES (PDL Only)

POLICY NAME:
NEUROPATHIC AGENTS – Lyrica, Gralise, Horizant, Savella
Effective Date: 03/22/2018

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Gabapentin, Duloxetine

Step 2 Drug(s): Gralise, Gralise Starter, Horizant, Lyrica, Savella

- Authorization for Lyrica, without a trial of a step 1 agent, may be given for patients with symptoms of seizure disorder.
- Authorization may be given for Lyrica if the patient has tried Horizant.
- Authorization for Lyrica may be given if the patient cannot tolerate gabapentin due to adverse events.
- Authorization for Lyrica may be given, without a trial of a step 1 agent, if the patient has symptoms of fibromyalgia.
- Authorization may be given for Lyrica if the patient has symptoms of generalized anxiety disorder (GAD) and has been previously treated with two drugs from the following drug classes - tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), or buspirone.

This step therapy program applies to new utilizers only.

POLICY NAME:
NSAIDs Oral
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** unique prescription strength generic NSAIDs (meloxicam, diclofenac sodium, dicolofenac potassium, etodolac, ibuprofen, indomethacin, flurbiprofen, fenoprofen calcium, ketoprofen, nabumetone, naproxen, naproxen sodium, piroxicam, tolmetin sodium, or sulindac) in the last 180 days, then authorization for step 2 drug maybe be given.

Step 1 Drug(s): meloxicam, diclofenac sodium, diclofenac potassium, etodolac, ibuprofen, indomethacin, flurbiprofen, fenoprofen calcium, ketoprofen, nabumetone, naproxen, naproxen sodium, piroxicam, tolmetin sodium, or sulindac

Step 2 Drug(s): celecoxib, mefenamic acid, Nalfon, Tivorbex, Zipsor

POLICY NAME:
OPIOIDS- Nucynta
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Hydromorphone, methadone, morphine, oxycodone, oxymorphone, tramadol

Step 2 Drug(s): Nucynta

POLICY NAME:
OPIOIDS (LONG-ACTING)- Exalgo, Hydromorphone ER,Hysingla ER, MS Contin, Nucynta ER, Opana ER, Oxycodone ER, Oxycontin, Zohydro ER
Effective Date: 01/01/2014

ST Policy Applicable To PDL Drug list ONLY

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug. If the patient has tried a Step 2 drug, then authorization may be given for a Step 3 drug.

Step 1 Drug(s): Fentanyl, Morphine Sulfate ER, Oxymorphone ER

Step 2 Drug(s): Hydromorphone ER, Oxycodone ER, MS Contin, Nucynta ER, Opana ER, Oxycontin

Step 3 Drug(s): Hysingla ER, Zohydro ER, Exalgo

- Authorization may be given for Exalgo, Oxycontin, or Nucynta ER if the patient has renal insufficiency.

- Authorization may be given for Oxycontin if the patient is pregnant.

POLICY NAME:
OPIOIDS (LONG-ACTING)- Hydromorphone ER, Nucynta ER, Oxycodone ER, Oxycontin
Effective Date: 01/01/2014

ST Policy Applicable To ID, OR and MT Drug List ONLY

Preferred Drug List	**ID Drug List**	**OR Drug List**	**MT Drug List**
No	**Yes**	**Yes**	**Yes**

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given for a Step 2 drug.

Step 1 Drug(s): Fentanyl, Morphine Sulfate ER, Oxymorphone ER.

Step 2 Drug(s): Hydromorphone ER, Oxycodone ER, Nucynta ER, Oxycontin

- Authorization may be given for Oxycontin, or Nucynta ER if the patient has renal insufficiency.
- Authorization may be given for Oxycontin if the patient is pregnant.

POLICY NAME:
OSMOLEX EXTENDED RELEASE
Effective Date: 06/13/2018

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried one Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Amantadine IR HCl Oral tablet

Step 2 Drug(s): Osmolex Extended Release 24 hour

POLICY NAME:
OVERACTIVE BLADDER
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Oxybutynin Chloride, Oxybutynin Chloride ER, Tolterodine, Tolterodine ER, Trospium Chloride.

Step 2 Drug(s): Darifenacin Hydrobromide ER, Gelnique, Myrbetriq, Oxytrol, Toviaz, Vesicare.

- Authorization for Oxytrol or Gelnique may be given for patients who cannot swallow or who have difficulty swallowing.

POLICY NAME:
PROTON PUMP INHIBITORS (PPI’s)
Effective Date: 02/10/2016

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs (at lease a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): Lansoprazole, Omeprazole, Pantoprazole, Rabeprazole

Step 2 Drug(s): Esomeprazole

- Authorization for esomeprazole may be given in patients less than 1 year of age.

POLICY NAME:
PRESTALIA (perindopril/amlodipine)
Effective Date: 10/22/2015

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Non-formulary	Non-formulary	Non-formulary

If the patient has tried a Step 1 drug (at least a 30 day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): benazepril/amlodipine

Step 2 Drug(s): Prestalia

POLICY NAME:
PROSTAGLANDINS OPHTHALMIC –Travatan Z, Zioptan
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30 day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): generic prostaglandin analogue (latanoprost)

Step 2 Drug(s): Lumigan, Travatan Z, Zioptan

POLICY NAME:
QUDEXY XR
Effective Date: 9/1/14

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried at least a 30 day trial of Step 1 drug, then authorization may be given.

Step 1 Drug(s): topiramate

Step 2 Drug(s): Qudexy XR

POLICY NAME:
RANEXA
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): A generic nitrate plus a generic beta blocker or a generic calcium channel blocker

Step 2 Drug(s): Ranexa

POLICY NAME:
ROSACEA TOPICAL-Soolantra, Mirvaso
Effective Date: 04/15/2015

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried **TWO** Step 1 drugs (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s): topical metronidazole, Finacea

Step 2 Drug(s): Soolantra, Mirvaso

POLICY NAME:
ANTI-HERPETIC AGENTS-Acyclovir ointment, Zovirax (acyclovir ointment/cream) Denavir (penciclovir cream), Sitavig (acyclovir buccal)
Effective Date: 9/1/14

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried **TWO** Step 1 drugs, then authorization may be given.

Step 1 Drug(s): Oral acyclovir, Oral famciclovir, Oral valacyclovir

Step 2 Drug(s): Sitavig, Acyclovir ointment, Zovirax ointment/cream, Denavir cream

POLICY NAME:
TOPICAL IMMUNOMODULATORS – Protopic (topical Tacrolimus), Eucrisa
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	Yes	Yes	Yes

If the patient has tried a Step 1 drug, then authorization for a Step 2 drug may be given.

Step 1 Drug(s): ALA-CORT, alclometasone dipropionate, amcinonide, betamethasone dipropionate, betamethasone dipropionate augmented, betamethasone valerate, clobetasol propionate, CLOBEX, clocortolone pivalate, desoximetasone, fluocinolone acetonide, fluocinonide, fluticasone propionate, halobetasol propionate, hydrocortisone, hydrocortisone butyrate, mometasone furoate, PEDIADERM HC, PEDIADERM TA, prednicarbate, scalacort, TEXACORT, triamcinolone acetonide, TRIANEX, TRIDERM, VERDESO

PDL ONLY: ALA-SCALP, APEXICON E, clobetasol emollient, CLODERM, CORDRAN TAPE, CUTIVATE, DERMASMOOTHE/FS, DERMASORB HC, DERMASORB TA, desonide, DESOWEN, DIPROLENE, DIPROLENE AF, ELOCON, fluocinonide emulsified, hydrocortisone valerate, LOCOID, LOCOID LIPOCREAM, LOKARA, PANDEL, SYNALAR, TEMOVATE, TEMOVATE E, TOPICORT, TRI-LUMA, ULTRAVATE, WESTCORT

Step 2 Drug(s): Protopic (PDL only), Tacrolimus (topical), Eucrisa

- Authorization may be given for Tacrolimus (topical), if the patient has tried one prescription strength topical corticosteroid for atopic dermatitis or eczema in the previous 60 days.
- Authorization for Tacrolimus (topical) may be given for patients with a dermatologic condition on or around the eyes, eyelids or genitalia.
- Authorization for Tacrolimus (topical) may be given for patients with the following conditions after a trial of a prescription strength topical corticosteroid: lichen planus, seborrheic dermatitis, chronic hand dermatitis, cutaneous lupus erythematosus or dermatomyositis or discoid lupus erythematosus, psoriasis, and vitiligo.
- Authorization for Tacrolimus (topical) may be given for patients with the following conditions after a trial of a prescription strength topical corticosteroid: dyshidrotic palmar eczema, pyoderma gangrenosum, orofacial or perineal Crohn's disease, erosive pustular dermatosis, chronic cutaneous graft-vs-host disease (GVHD), chronic actinic dermatitis, allergic contact dermatitis, and bullous pemphigoid.

- Authorization may be given for Tacrolimus (topical), for steroid-induced rosacea if the patient has tried **two** therapies for rosacea (e.g., azelaic acid, topical metronidazole, topical tretinoin products, oral antibiotics [e.g., tetracycline, metronidazole, doxycycline, minocycline, clarithromycin], or oral isotretinoin).

- Authorization may be given for Tacrolimus (topical), for severe uremic pruritus if the patient has tried **two** other therapies for this condition (e.g., emollients, capsaicin, topical corticosteroids, ultraviolet B irradiation).

POLICY NAME:
TRIPTAN AGENTS – Almotriptan, Axert, Frovatriptan, Eletriptan, Zomig Nasal
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried **TWO** Step 1 drugs (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s):): Naratriptan, Sumatriptan, Rizatriptan, Rizatriptan oral disintegrating tablet (ODT), Zolmitriptan, Zolmitriptan ODT

Step 2 Drug(s): Almotriptan, Axert, Frovatriptan, Eletriptan, Zomig Nasal

POLICY NAME:
TRIPTAN AGENTS – Almotriptan, Axert, Frovatriptan, Frova, Eletriptan, Relpax, Zomig Nasal
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
Yes	No	No	No

If the patient has tried **TWO** Step 1 drugs (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given.

Step 1 Drug(s):): Naratriptan, Amerge, Sumatriptan, Imitrex, Rizatriptan, Maxalt, Rizatriptan oral-disintegrating tablet (ODT), Maxalt-MLT, Zolmitriptan, Zomig, Zolmitriptan ODT, Zomig ZMT

Step 2 Drug(s): Almotriptan, Axert, Frovatriptan, Frova, Eletriptan, Relpax, Zomig Nasal

POLICY NAME:
ULORIC
Effective Date: 01/01/2014

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List
No	Yes	Yes	Yes

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization may be given.

Step 1 Drug(s): Allopurinol, Probenecid, Probenecid- Colchicine

Step 2 Drug(s): Uloric