



## 2022 PacificSource Health Plans Step Therapy Criteria

Last Modified: 07/22/2022  
(All criteria reviewed at least once per year)

### Table of Contents

ACTICLATE .....	3
ANTIDEPRESSANTS – Drizalma, Fetzima, fluoxetine 90mg (weekly), fluvoxamine ER, olanzapine-fluoxetine, Viibryd, Viibryd starter pack, Trintellix, Pexeva .....	4
ANTI-HERPETIC AGENTS-Acyclovir ointment, Acyclovir cream, Zovirax (acyclovir ointment/cream) Denavir (penciclovir cream), Sitavig (acyclovir buccal).....	5
ATYPICAL ANTIPSYCHOTICS – Asenapine, Fanapt, Invega Sustenna, Latuda, Saphris, Paliperidone ER, Quetiapine ER, Rexulti, Seroquel XR, Vraylar, Caplyta.....	6
BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY – Dutasteride, Dutasteride-Tamsulosin, Cardura XL, Jalyn .....	7
CONSTIPATION AGENTS – Linzess, Lubiprostone .....	8
ECOZA (econazole 1% foam).....	9
ENDARI (L-glutamine) .....	10
FIBRATES – Triglide .....	11
INSOMNIA AGENTS – Belsomra, doxepin, Dayvigo, Edluar, Intermezzo, Silenor, zolpidem sublingual tablet (SL), Quviviq.....	12
Megestrol Acetate 625mg/5mL oral suspension.....	13
MIGRAINE AGENTS – Almotriptan, Axert, Frovatriptan, Frova, Zolmitriptan Nasal, Zomig Nasal, Ubrelvy .....	14
NEUROPATHIC AGENTS – Gralise, Horizant, Savella.....	15
OPIOIDS- Nucynta .....	16
OPIOIDS (LONG-ACTING)- Exalgo, Hydrocodone Bitartrate Cap ER 12HR, Hydromorphone ER, Hysingla ER, MS Contin, Nucynta ER, Opana ER, Oxycodone ER, Oxycontin, Zohydro ER.....	17
OSMOLEX EXTENDED RELEASE .....	18
OVERACTIVE BLADDER.....	19
PRESTALIA (perindopril/amlodipine) .....	20
PROSTAGLANDINS OPHTHALMIC –Travatan Z, Zioptan .....	21
ROSACEA TOPICAL-Soolantra, Mirvaso, ivermectin 1% cream, Zilxi .....	22





**POLICY NAME:**

ACTICLATE

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	No	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 hyclate tablet (20mg, 100mg), doxycycline hyclate capsule (50mg, 100mg), doxycycline hyclate delayed release tablet (75mg, 100mg, 150mg), doxycycline monohydrate capsule (50mg, 75mg, 100mg, 150mg), doxycycline monohydrate tablet (50mg, 75mg, 100mg, 150mg)

**Step 2 Drug(s):** Acticlate, doxycycline hyclate 75mg tablet, doxycycline hyclate 150mg tablet



**POLICY NAME:**

ANTIDEPRESSANTS – Drizalma, Fetzima, fluoxetine 90mg (weekly), fluvoxamine ER, olanzapine-fluoxetine, Viibryd, Viibryd starter pack, Trintellix, Pexeva

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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/WA Drug Lists:** bupropion, bupropion SR (12-hour), bupropion XL (24-hour), citalopram, desvenlafaxine extended release (ER), duloxetine, 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, Duloxetine

**Step 2 Drug(s):**

**Preferred and ID/OR/MT/WA Drug Lists:** fluoxetine 90mg (weekly), fluvoxamine ER, Trintellix, Viibryd, Viibryd starter pack, Pexeva

**Preferred Drug List only:** Prozac weekly, Fetzima, olanzapine-fluoxetine, Drizalma



**POLICY NAME:**

ANTI-HERPETIC AGENTS-Acyclovir ointment, Acyclovir cream, Zovirax (acyclovir ointment/cream) Denavir (penciclovir cream), Sitavig (acyclovir buccal)

ST Policy Applicable to:

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

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

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

**Step 2 Drug(s):** Acyclovir cream

**PDL ONLY:** Sitavig, Zovirax cream, Denavir cream



**POLICY NAME:**

ATYPICAL ANTIPSYCHOTICS – Asenapine, Fanapt, Invega Sustenna, Latuda, Saphris, Paliperidone ER, Quetiapine ER, Rexulti, Seroquel XR, Vraylar, Caplyta

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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 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):** Aripiprazole, Olanzapine, Quetiapine, Quetiapine ER, Risperidone, Ziprasidone

**PDL ONLY:** Abilify, Geodon, Risperdal, Seroquel, Seroquel XR, Zyprexa

**Step 2 Drug(s):** Asenapine, Fanapt, Invega Sustenna, Latuda, Paliperidone ER, Rexulti, Secuado, Vraylar

**PDL ONLY:** Invega ER, Saphris

**Step 3 Drug(s):** Caplyta



**POLICY NAME:**

BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY – Dutasteride, Dutasteride-Tamsulosin, Cardura XL, Jalyn

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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, silodosin, terazosin, tamsulosin

**PDL Only:** Rapaflo

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



**POLICY NAME:**

CONSTIPATION AGENTS – Linzess, Lubiprostone

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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):** Linzess, Lubiprostone





**POLICY NAME:**

ECOZA (econazole 1% foam)

ST Policy Applicable To:

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

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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:**  
FIBRATES – Triglide

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
No	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):** At least a 30 day supply of a generic fibrate within the past 365 days.

**Step 2 Drug(s):** Triglide



**POLICY NAME:**

INSOMNIA AGENTS – Belsomra, doxepin, Dayvigo, Edluar, Intermezzo, Silenor, zolpidem sublingual tablet (SL), Quviviq

ST Policy Applicable To:

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

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

**Step 1 Drugs:** eszopiclone, zolpidem, zolpidem extended release (ER), zaleplon, temazepam, triazolam, ramelteon

**Preferred Drug List Only:** Rozerem

**Step 2 Drugs:** Dayvigo

**Preferred Drug List Only:** doxepin (3 mg and 6 mg tablet), Belsomra, Edluar, Intermezzo, Silenor, zolpidem sublingual tablet (SL), Quviviq



**POLICY NAME:**

Megestrol Acetate 625mg/5mL oral suspension

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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:**

MIGRAINE AGENTS – Almotriptan, Axert, Frovatriptan, Frova, Zolmitriptan Nasal, Zomig Nasal, Ubrelvy

ST Policy Applicable To:

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

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

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

**PDL ONLY:** Amerge, Imitrex, Maxalt, Maxalt-MLT, Relpax, Zomig, Zomig ZMT

**Step 2 Drug(s):** Almotriptan, Frovatriptan, Ubrelvy, Zolmitriptan Nasal

**PDL ONLY:** Axert, Frova, Zomig Nasal



**POLICY NAME:**

NEUROPATHIC AGENTS – Galise, Horizant, Savella

ST Policy Applicable to:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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, Pregabalin

**Step 2 Drug(s):** Galise, Galise Starter, Horizant, Savella



**POLICY NAME:**  
OPIOIDS- Nucynta

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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, Hydrocodone Bitartrate Cap ER 12HR, Hydromorphone ER, Hysingla ER, MS Contin, Nucynta ER, Opana ER, Oxycodone ER, Oxycontin, Zohydro ER

**ST Policy Applicable To PDL, ID, OR, MT and WA Drug List**

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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 for a Step 2 drug.

**Step 1 Drug(s):** Buprenorphine Weekly Patch, Fentanyl, Morphine Sulfate ER, Oxymorphone ER.

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

**Step 3 Drug(s):** Hydrocodone Bitartrate Cap ER 12HR  
**PDL ONLY:** Hysingla ER, Zohydro ER, Exalgo



**POLICY NAME:**

OSMOLEX EXTENDED RELEASE

ST Policy Applicable To:

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

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	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 Oral Syrup, Oxybutynin Chloride Extended Release (ER), solifenacin, Tolterodine, Tolterodine ER, Trospium Chloride.

**Preferred Drug List Only:** Vesicare

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

**Preferred Drug List Only:** Enablex, Gemtesa

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



**POLICY NAME:**

PRESTALIA (perindopril/amlodipine)

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
Yes	Non-Formulary	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

ST Policy Applicable To:

Preferred Drug List	ID Drug List	OR Drug List	MT Drug List	WA Drug List
No	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):** latanoprost 0.005%, bimatoprost 0.03%

**Step 2 Drug(s):** travoprost 0.004%, Lumigan, Zioptan



**POLICY NAME:**

ROSACEA TOPICAL-Soolantra, Mirvaso, ivermectin 1% cream, Zilxi

ST Policy Applicable To:

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

If the patient has tried a 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, azelaic acid gel 15%, Finacea Foam 15%,

**PDL Only:** Finacea Gel 15%

**Step 2 Drug(s):** Mirvaso Gel 0.33%, ivermectin 1% cream

**PDL Only:** Soolantra, Zilxi