

## **Step Therapy Criteria**

<b>Step Therapy Group</b>	ANTIEMETICS
<b>Drug Names</b>	GRANISETRON HCL, SANCUSO
<b>Step Therapy Criteria</b>	You are required to have previous therapy with oral ondansetron before we will cover granisetron oral tablet or granisetron transdermal (Sancuso).
<b>Step Therapy Group</b>	BISPHOSPHONATES
<b>Drug Names</b>	RISEDRONATE SODIUM, RISEDRONATE SODIUM DR
<b>Step Therapy Criteria</b>	You are required to have previous therapy with a generic oral bisphosphonate (e.g. alendronate or ibandronate) before we will cover risedronate (generic for Actonel or Atelvia).
<b>Step Therapy Group</b>	CLONAZEPAM ODT
<b>Drug Names</b>	CLONAZEPAM ODT
<b>Step Therapy Criteria</b>	You are required to have previous therapy with clonazepam before we will cover clonazepam ODT.
<b>Step Therapy Group</b>	CLOZAPINE ODT
<b>Drug Names</b>	CLOZAPINE ODT
<b>Step Therapy Criteria</b>	You are required to have previous therapy with clozapine tablets before we will cover clozapine ODT (Fazaclo).
<b>Step Therapy Group</b>	DESVENLAFAXINE
<b>Drug Names</b>	DESVENLAFAXINE ER
<b>Step Therapy Criteria</b>	You are required to have previous therapy with venlafaxine (IR or ER) AND 1 selective serotonin reuptake inhibitor (SSRI) such as sertraline or paroxetine before we will cover desvenlafaxine ER.
<b>Step Therapy Group</b>	FEBUXOSTAT
<b>Drug Names</b>	ULORIC
<b>Step Therapy Criteria</b>	You are required to have previous therapy with allopurinol before we will cover febuxostat (Uloric).
<b>Step Therapy Group</b>	FIDAXOMICIN
<b>Drug Names</b>	DIFICID
<b>Step Therapy Criteria</b>	You are required to have previous therapy with oral or intravenous vancomycin or oral metronidazole before we will cover fidaxomicin (Dificid).

<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>HYPNOTIC</p> <p>ZALEPLON, ZOLPIDEM TARTRATE</p> <p>You are required to have previous therapy with 1 of the following medications before we will cover zolpidem or zaleplon: trazodone, Rozerem, or Silenor.</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>OPHTHALMIC PROSTAGLANDINS</p> <p>BIMATOPROST, TRAVATAN Z, ZIOPTAN</p> <p>You are required to have previous therapy with latanoprost before we will cover bimatoprost, Travatan Z, or tafluprost (Zioptan).</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>PROTON PUMP INHIBITORS</p> <p>DEXILANT</p> <p>You are required to have previous therapy with prescription omeprazole, lansoprazole, or pantoprazole before we will cover dexlansoprazole (Dexilant).</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>SYMLIN</p> <p>SYMLINPEN 120, SYMLINPEN 60</p> <p>You are required to have previous therapy with insulin before we will cover Symlin.</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TEKTURNA</p> <p>TEKTURNA, TEKTURNA HCT</p> <p>You are required to have previous therapy with an angiotensin-converting enzyme (ACE) inhibitor (e.g. lisinopril), or an ACE inhibitor combination product (e.g. lisinopril-HCTZ), or an angiotensin II Receptor Blocker (ARB)(e.g. Losartan), or an ARB combination product (e.g. Losartan-HCT) before we will cover Tekturna or Tekturna HCT.</p>
<p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p>	<p>TERIPARATIDE</p> <p>FORTEO</p> <p>You are required to have previous therapy with a bisphosphonate (e.g. alendronate) or raloxifene before we will cover teriparatide (Forteo).</p>