## ATYPICALS

### Products Affected

**Step 2:**
- ABILIFY MYCITE TABLET 10 MG ORAL
- ABILIFY MYCITE TABLET 15 MG ORAL
- ABILIFY MYCITE TABLET 2 MG ORAL
- ABILIFY MYCITE TABLET 20 MG ORAL
- ABILIFY MYCITE TABLET 30 MG ORAL
- ABILIFY MYCITE TABLET 5 MG ORAL
- FANAPT TABLET 1 MG ORAL
- FANAPT TABLET 10 MG ORAL
- FANAPT TABLET 12 MG ORAL
- FANAPT TABLET 2 MG ORAL
- FANAPT TABLET 4 MG ORAL
- FANAPT TABLET 6 MG ORAL
- FANAPT TABLET 8 MG ORAL
- FANAPT TITRATION PACK TABLET 1 & 2 & 4 & 6 MG ORAL

<table>
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<tr>
<th>Criteria</th>
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<tr>
<td>Claim will pay automatically for Abilify MyCite, Fanapt, Geodon IM, Latuda, Versacloz, Vraylar, or Zyprexa IM if enrollee has a paid claim for at least a 1 days supply of any generic formulary atypical antipsychotic in the past 365 days. Otherwise Abilify MyCite, Fanapt, Geodon IM, Latuda, Versacloz, Vraylar, or Zyprexa IM requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary atypical antipsychotic, OR (2) history of adverse event with any generic formulary atypical antipsychotic, OR (3) any generic formulary atypical antipsychotic is contraindicated.</td>
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</table>
**DHE**

**Products Affected**

**Step 2:**
- dihydroergotamine mesylate solution 4 mg/ml nasal

**Details**

| Criteria | Claim will pay automatically for DHE if enrollee has a paid claim for at least a 1 days supply of any generic formulary serotonin (5-HT) 1b/1d receptor agonist (i.e. triptan) in the past 365 days. Otherwise, DHE requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary triptan, OR (2) history of adverse event with any generic formulary triptan, OR (3) any generic formulary triptan is contraindicated. |

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Formulary ID: 20205 Version 15
Last Updated: 07/09/2020
Effective date: 08/01/2020
Y0110_PH_StepTherapyCriteria IA 12/21/2016
DIFICID

Products Affected
Step 2:
- DIFICID TABLET 200 MG ORAL

Details

| Criteria | Claim will pay automatically for Dificid if enrollee has a paid claim for at least a 1 days supply of Vancomycin in the past 120 days. Otherwise, Dificid requires a step therapy exception request indicating: (1) history of inadequate treatment response with Vancomycin, OR (2) history of adverse event with Vancomycin, OR (3) Vancomycin is contraindicated. |

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Y0110_PH_StepTherapyCriteria IA 12/21/2016
PPI

Products Affected

Step 2:

- **DEXILANT CAPSULE DELAYED RELEASE 30 MG ORAL**
- **DEXILANT CAPSULE DELAYED RELEASE 60 MG ORAL**

Details

| Criteria | Claim will pay automatically for Dexilant if enrollee has a paid claim for at least a 1 days supply of any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole in the past 365 days. Otherwise, Dexilant requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole OR (2) history of adverse event with any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole, OR (3) any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole are contraindicated. |
RHOPRESSA

Products Affected
Step 2:
- RHOPRESSA SOLUTION 0.02 % OPHTHALMIC

Details

| Criteria | Claim will pay automatically for Rhopressa if enrollee has a paid claim for at least a one day supply of any step level 1 agent (Alphagan P, Azopt, Phospholine Iodide, or any generic formulary antiglaucoma agent). Otherwise, Rhopressa requires a step therapy exception request indicating: (1) history of inadequate treatment response with step 1 agent, OR (2) history of adverse event with step 1 agent, OR (3) step 1 agent is contraindicated. |
RYTARY

Products Affected

Step 2:
- RYTARY CAPSULE EXTENDED RELEASE 23.75-95 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 36.25-145 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 48.75-195 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 61.25-245 MG ORAL

Details

| Criteria | Claim will pay automatically for Rytary if enrollee has a paid claim for at least a 1 days supply of a combination carbidopa/levodopa product in the past 365 days. Otherwise, Rytary requires a step therapy exception request indicating: (1) History of inadequate treatment response with a combination carbidopa/levodopa product, or (2) History of adverse event with a combination carbidopa/levodopa product, or (3) A combination carbidopa/levodopa product is contraindicated. |
## SGLT2

### Products Affected

**Step 2:**

- INVOKAMET TABLET 150-1000 MG ORAL
- INVOKAMET TABLET 150-500 MG ORAL
- INVOKAMET TABLET 50-1000 MG ORAL
- INVOKAMET TABLET 50-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL
- INVOKANA TABLET 100 MG ORAL
- INVOKANA TABLET 300 MG ORAL
- JARDIANCE TABLET 10 MG ORAL
- JARDIANCE TABLET 25 MG ORAL
- SYNJARDY TABLET 12.5-1000 MG ORAL
- SYNJARDY TABLET 12.5-500 MG ORAL
- SYNJARDY TABLET 5-1000 MG ORAL
- SYNJARDY TABLET 5-500 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL

### Details

**Criteria**

Claim will pay automatically for Invokana, Invokamet IR/XR, Jardiance, or Synjardy IR/XR if enrollee has a paid claim for at least a 1 days supply of generic metformin or a combination generic metformin product in the past 365 days. Otherwise, Invokana, Invokamet IR/XR, Jardiance, or Synjardy IR/XR requires a step therapy exception request indicating: 
1. History of inadequate treatment response with generic metformin or a combination generic metformin product, or 
2. History of adverse event with generic metformin or a combination generic metformin product, or 
3. Generic metformin or a combination generic metformin product is contraindicated.

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Formulary ID: 20205 Version 15
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Effective date: 08/01/2020
Y0110_PH_StepTherapyCriteria IA 12/21/2016
## TOPICAL ANTI-INFLAMMATORY

### Products Affected

**Step 2:**

- EUCRISA OINTMENT 2 % EXTERNAL
- pimecrolimus cream 1 % external
- tacrolimus ointment 0.03 % external
- tacrolimus ointment 0.1 % external

### Details

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>Claim will pay automatically for pimecrolimus, Eucrisa, or Tacrolimus External if enrollee has a paid claim for at least a 1 days supply of any formulary topical corticosteroid in the past 365 days. Otherwise, pimecrolimus, Eucrisa, or Tacrolimus External requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary topical corticosteroid, OR (2) history of adverse event with any formulary topical corticosteroid, OR (3) any formulary topical corticosteroid is contraindicated.</td>
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ULORIC

Products Affected
Step 2:
- febuxostat tablet 40 mg oral
- febuxostat tablet 80 mg oral

Details

| Criteria | Claim will pay automatically for Febuxostat if enrollee has a paid claim for at least a 1 days supply of Allopurinol in the past 365 days. Otherwise, Febuxostat requires a step therapy exception request indicating: (1) history of inadequate treatment response with Allopurinol, OR (2) history of adverse event with Allopurinol, OR (3) Allopurinol is contraindicated. |

Formulary ID: 20205 Version 15
Last Updated: 07/09/2020
Effective date: 08/01/2020
Y0110_PH_StepTherapyCriteria IA 12/21/2016
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