

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
- GEODON SOLUTION RECONSTITUTED 20 MG INTRAMUSCULAR
- LATUDA TABLET 120 MG ORAL
- LATUDA TABLET 20 MG ORAL
- LATUDA TABLET 40 MG ORAL
- LATUDA TABLET 60 MG ORAL
- LATUDA TABLET 80 MG ORAL
- VERSACLOZ SUSPENSION 50 MG/ML ORAL
- VRAYLAR CAPSULE 1.5 MG ORAL
- VRAYLAR CAPSULE 3 MG ORAL
- VRAYLAR CAPSULE 4.5 MG ORAL
- VRAYLAR CAPSULE 6 MG ORAL
- VRAYLAR CAPSULE THERAPY PACK 1.5 & 3 MG ORAL
- ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 210 MG INTRAMUSCULAR

Details

Criteria	
	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.

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Y0110_PH_StepTherapyCriteria IA 12/21/2016

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.

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.

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.
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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	
	<p>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.</p>

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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

Criteria	Details
	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.

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.
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Memorial Hermann 2020 Formulary 2020 Step Therapy Criteria



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Memorial Hermann 2020 Formulary 2020 Step Therapy Criteria



MEMORIAL HERMANN ADVANTAGE
HMO

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 RELEASE 24 HOUR 12.5-1000 MG
 ORAL..... 7
 SYNJARDY XR TABLET EXTENDED
 RELEASE 24 HOUR 25-1000 MG
 ORAL..... 7
 SYNJARDY XR TABLET EXTENDED
 RELEASE 24 HOUR 5-1000 MG ORAL
 7

T
 tacrolimus ointment 0.03 % external 8
 tacrolimus ointment 0.1 % external 8

V
 VERSACLOZ SUSPENSION 50 MG/ML
 ORAL..... 1
 VRAYLAR CAPSULE 1.5 MG ORAL 1
 VRAYLAR CAPSULE 3 MG ORAL 1
 VRAYLAR CAPSULE 4.5 MG ORAL 1
 VRAYLAR CAPSULE 6 MG ORAL 1
 VRAYLAR CAPSULE THERAPY PACK
 1.5 & 3 MG ORAL 1

Z
 ZYPREXA RELPREVV SUSPENSION
 RECONSTITUTED 210 MG
 INTRAMUSCULAR 1