ANTICONVULSANTS

Products Affected

Step 2:

- CELONTIN CAPSULE 300 MG ORAL
- PEGANONE TABLET 250 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 1000 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 250 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 500 MG ORAL
- SPRITAM TABLET DISINTEGRATING SOLUBLE 750 MG ORAL
- VIMPAT SOLUTION 10 MG/ML ORAL
- VIMPAT TABLET 100 MG ORAL
- VIMPAT TABLET 150 MG ORAL
- VIMPAT TABLET 200 MG ORAL
- VIMPAT TABLET 50 MG ORAL

Details

Criteria	Claim will pay automatically for Celontin, Peganone, Spritam, or Vimpat, if enrollee has a paid claim for at least a 1 days supply of a Generic Anticonvulsant or Lamictal XR in the past 365 days. Otherwise, Celontin, Peganone, Spritam, or Vimpat require a step therapy exception request indicating: (1) history of inadequate treatment response with Generic Anticonvulsants or Lamictal XR, OR (2) history of adverse event with Generic Anticonvulsants or Lamictal XR, OR (3)Generic Anticonvulsants or Lamictal XR is contraindicated.

ANTIDEPRESSANTS

Products Affected

Step 2:

- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 174 MG ORAL
- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 348 MG ORAL
- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 522 MG ORAL
- KHEDEZLA TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL
- KHEDEZLA TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL
- TRINTELLIX TABLET 10 MG ORAL
- TRINTELLIX TABLET 20 MG ORAL
- TRINTELLIX TABLET 5 MG ORAL

Details

Criteria	Claim will pay automatically for Aplenzin, Khedezla, or Trintellix if enrollee has a paid claim for at least a 1 days supply of any generic formulary antidepressants in the member's overall utilization history (lifetime). Otherwise, Aplenzin, Khedezla, or Trintellix requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary antidepressant , OR (2) history of adverse event with any generic formulary antidepressant , OR (3) any generic formulary antidepressant is contraindicated.

ATYPICALS

Products Affected

Step 2:

- 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
- FAZACLO TABLET DISPERSIBLE 100 MG ORAL
- FAZACLO TABLET DISPERSIBLE 12.5 MG ORAL
- FAZACLO TABLET DISPERSIBLE 150 MG ORAL
- FAZACLO TABLET DISPERSIBLE 200 MG ORAL
- FAZACLO TABLET DISPERSIBLE 25 MG ORAL
- GEODON SOLUTION RECONSTITUTED 20 MG INTRAMUSCULAR
- SAPHRIS TABLET SUBLINGUAL 10 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 2.5 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 5 MG SUBLINGUAL
- 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

Details

Criteria	Claim will pay automatically for Fanapt, Fazaclo, Geodon solution, Saphris, or Vraylar if enrollee has a paid claim for at least a 1 days supply 1 days supply of any generic formulary atypical antipsychotic member's overall utilization history (lifetime). Otherwise, Fanapt, Fazaclo, Geodon solution, Saphris, or Vraylar 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.

BISPHOSPHONATES

Products Affected

Step 2:

- *alendronate sodium solution 70 mg/75ml oral*
- FOSAMAX PLUS D TABLET 70-2800 MG-UNIT ORAL
- FOSAMAX PLUS D TABLET 70-5600 MG-UNIT ORAL
- *ibandronate sodium tablet 150 mg oral*
- *risedronate sodium tablet 150 mg oral*
- *risedronate sodium tablet 30 mg oral*
- *risedronate sodium tablet 35 mg oral*
- *risedronate sodium tablet 35 mg oral (12 pack)*
- *risedronate sodium tablet 35 mg oral (4 pack)*
- *risedronate sodium tablet 5 mg oral*

Details

Criteria	Claim will pay automatically for Alendronate solution, Fosamax Plus D, Ibandronate, or Risedronate if enrollee has a paid claim for at least a 1 days supply of Alendronate tablets in the member's overall utilization history (lifetime). Otherwise, Alendronate solution, Fosamax Plus D, Ibandronate, or Risedronate requires a step therapy exception request indicating: (1) history of inadequate treatment response with Alendronate tablets, OR (2) history of adverse event with Alendronate tablets, OR (3) Alendronate tablets are contraindicated.

DIFICID

Products Affected

Step 2:

- DIFICID TABLET 200 MG ORAL

Details

Criteria	Claim will pay automatically for Dificid if the enrollee has paid claims history of any 1 days supply of Vancomycin capsules or Firvanq in the member's overall utilization history (lifetime). Otherwise Dificid requires a step therapy exception request indicating: (1) history of inadequate treatment response with Vancomycin capsules or Firvanq OR (2) history of adverse event with Vancomycin capsules or Firvanq OR (3) Vancomycin capsules or Firvanq 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 the enrollee has paid claims history of any 1 days supply of any single Step 1 agent in the member's overall utilization history (lifetime). Step 1 Drugs are: esomeprazole, lansoprazole (OTC or RX), omeprazole (OTC or RX), pantoprazole, Prilosec (OTC), Prevacid (OTC), Zegerid (omeprazole-sodium bicarbonate) (OTC). Otherwise, Dexilant requires a step therapy exception request indicating: (1) history of inadequate treatment response with Step 1 Drugs OR (2) history of adverse event with Step 1 Drugs OR (3) Step 1 Drugs are contraindicated

RHEUMATOID ARTHRITIS

Products Affected

Step 2:

- ACTEMRA ACTPEN SOLUTION AUTO-INJECTOR 162 MG/0.9ML SUBCUTANEOUS
- ACTEMRA SOLUTION PREFILLED SYRINGE 162 MG/0.9ML SUBCUTANEOUS
- CIMZIA KIT 2 X 200 MG SUBCUTANEOUS
- CIMZIA PREFILLED KIT 2 X 200 MG/ML SUBCUTANEOUS
- COSENTYX 300 DOSE SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS
- COSENTYX SENSOREADY 300 DOSE SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS
- KINERET SOLUTION PREFILLED SYRINGE 100 MG/0.67ML SUBCUTANEOUS
- ORENCIA CLICKJECT SOLUTION AUTO-INJECTOR 125 MG/ML SUBCUTANEOUS
- ORENCIA SOLUTION PREFILLED SYRINGE 125 MG/ML SUBCUTANEOUS
- ORENCIA SOLUTION PREFILLED SYRINGE 50 MG/0.4ML SUBCUTANEOUS
- ORENCIA SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML SUBCUTANEOUS
- SIMPONI SOLUTION AUTO-INJECTOR 100 MG/ML SUBCUTANEOUS
- SIMPONI SOLUTION AUTO-INJECTOR 50 MG/0.5ML SUBCUTANEOUS
- SIMPONI SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS
- SIMPONI SOLUTION PREFILLED SYRINGE 50 MG/0.5ML SUBCUTANEOUS
- STELARA SOLUTION 45 MG/0.5ML SUBCUTANEOUS
- STELARA SOLUTION PREFILLED SYRINGE 45 MG/0.5ML SUBCUTANEOUS
- STELARA SOLUTION PREFILLED SYRINGE 90 MG/ML SUBCUTANEOUS
- XELJANZ TABLET 10 MG ORAL
- XELJANZ TABLET 5 MG ORAL

Details

Criteria	Claim will pay automatically for the requested drug (Actemra, Cimzia, Cosentyx, Kineret, Orencia, Simponi, Stelara or Xeljanz) if enrollee has a paid claim for at least a 1 days supply of Humira AND Enbrel in the member's overall utilization history (lifetime). Otherwise, the requested drug requires a step therapy exception request indicating: (1) history of inadequate treatment response with Humira AND Enbrel, (Exceptions-ACTEMRA will be approved for giant cell arteritis (GCA) without prior therapy AND Kineret will be approved for cryopyrin-associated periodic syndromes (CAPS) without prior therapy) OR(2) history of adverse event with Humira AND Enbrel, OR (3) Humira AND Enbrel are contraindicated. IF diagnosis is Crohn's disease OR ulcerative colitis, ONLY requires trial of Humira.

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 generic Carbidopa/Levodopa in the member's overall utilization history (lifetime). Otherwise, Rytary requires a step therapy exception request indicating: (1) history of inadequate treatment response with Carbidopa/Levodopa , OR (2) history of adverse event with Carbidopa/Levodopa , OR (3) Carbidopa/Levodopa is contraindicated.

ULORIC

Products Affected

Step 2:

- ULORIC TABLET 40 MG ORAL
- ULORIC TABLET 80 MG ORAL

Details

Criteria	Claim will pay automatically for Uloric if enrollee has a paid claim for at least a 1 days supply of Allopurinol in the member's overall utilization history (lifetime). Otherwise, Uloric 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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