

## Step Therapy Criteria

|                              |  |
|------------------------------|--|
| <b>Step Therapy Group</b>    | ARIPIPRAZOLE ODT   |
| <b>Drug Names</b>            | ARIPIPRAZOLE ODT   |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a 30-day supply of generic aripiprazole immediate release tablet has been tried.   |
| <b>Step Therapy Group</b>    | BARACLUDE SOL  |
| <b>Drug Names</b>            | BARACLUDE  |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a [30-day] supply of generic entecavir tablets has been tried.   |
| <b>Step Therapy Group</b>    | BISPHOSPHONATES  |
| <b>Drug Names</b>            | ALENDRONATE SODIUM, RISEDRONATE SODIUM DR  |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a [30-day] supply of alendronate, ibandronate, or risedronate has been tried.  |
| <b>Step Therapy Group</b>    | BRINZOLAMIDE   |
| <b>Drug Names</b>            | BRINZOLAMIDE   |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a 30-day supply of dorzolamide 2% ophthalmic solution has been tried.  |
| <b>Step Therapy Group</b>    | EDARBI-EDARBYCLOR  |
| <b>Drug Names</b>            | EDARBI, EDARBYCLOR   |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a [30-day] supply of two formulary generic Angiotensin II Receptor Antagonists (ARBs) or ARB combination products have been tried.   |
| <b>Step Therapy Group</b>    | HMG-COA INHIBITORS   |
| <b>Drug Names</b>            | EZALLOR SPRINKLE, FLUVASTATIN, FLUVASTATIN SODIUM ER, PITAVASTATIN CALCIUM, ZYPITAMAG  |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a [30-day] supply of atorvastatin tablets, ezetimibe/simvastatin, lovastatin, pravastatin, rosuvastatin tablets, simvastatin tablets, or amlodipine/atorvastatin has been tried. |
| <b>Step Therapy Group</b>    | LAMOTRIGINE  |
| <b>Drug Names</b>            | LAMOTRIGINE ER, LAMOTRIGINE ODT, SUBVENITE   |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a 30-day supply of generic lamotrigine immediate release tablets or generic lamotrigine chewable, dispersible tablet has been tried.   |
| <b>Step Therapy Group</b>    | LEVALBUTEROL   |
| <b>Drug Names</b>            | LEVALBUTEROL TARTRATE HFA  |
| <b>Step Therapy Criteria</b> | Coverage will be provided if at least a 30-day supply of albuterol HFA or Ventolin HFA has been tried.   |

|   |   |
|---|---|
| <p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p> | <p>OLANZAPINE ODT</p> <p>OLANZAPINE ODT</p> <p>Coverage will be provided if at least a 30-day supply of generic olanzapine immediate release tablet has been tried.</p>   |
| <p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p> | <p>PPI</p> <p>ESOMEPRAZOLE MAGNESIUM, LANSOPRAZOLE</p> <p>Coverage will be provided if at least a 30-day supply of two of the following generic alternatives: omeprazole capsules, pantoprazole tablets, or lansoprazole capsules have been tried.</p>  |
| <p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p> | <p>RISPERIDONE ODT</p> <p>RISPERIDONE ODT</p> <p>Coverage will be provided if at least a 30-day supply of generic risperidone immediate release tablet has been tried.</p>  |
| <p><b>Step Therapy Group</b></p> <p><b>Drug Names</b></p> <p><b>Step Therapy Criteria</b></p> | <p>URINARY ANTISPASMODICS</p> <p>DARIFENACIN HYDROBROMIDE</p> <p>Coverage will be provided if at least a 30-day supply of one of the following generics have been tried: oxybutynin tablets, oxybutynin solution, oxybutynin extended-release tablets, solifenacin tablets, tolterodine immediate-release tablets, or trospium immediate-release tablets.</p> |