

2026 STEP THERAPY CRITERIA

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Step Therapy Group:

Oral Inhalers ST - Advair Diskus

Drug Name(s)

Advair Diskus

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Oral Inhalers ST - Spiriva Handihaler

Drug Name(s)

Spiriva Handihaler

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Oral Inhalers ST – Symbicort

Drug Name(s)

Symbicort

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

PPI ST – Aciphex

Drug Name(s)

Aciphex

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

PPI ST – Nexium

Drug Name(s)

Nexium

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

PPI ST – Prevacid

Drug Name(s)

Prevacid

Prevacid Solutab

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

PPI ST – Protonix

Drug Name(s)

Protonix

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Statins ST – Crestor

Drug Name(s)

Crestor

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Statins ST - Lescol XL

Drug Name(s)

Lescol XL

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Statins ST – Lipitor

Drug Name(s)

Lipitor

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Statins ST – Vytorin

Drug Name(s)

Vytorin

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Statins ST – Zocor

Drug Name(s)

Zocor

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Triptans ST - Imitrex tablet

Drug Name(s)

Imitrex Tablet

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Triptans ST – Maxalt

Drug Name(s)

Maxalt

Maxalt-MLT

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Triptans ST – Relpax

Drug Name(s)

Relpax

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Triptans ST – Treximet

Drug Name(s)

Treximet

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.

Step Therapy Group:

Urinary Incontinence ST - Toviaz

Drug Name(s)

Toviaz

Criteria:

Criteria for approval require ONE of the following:

1. Patient's medication history includes use of the generic equivalent agent within the past 999 days OR
2. Patient has an intolerance or hypersensitivity to the generic equivalent agent OR
3. Patient has had an ineffective treatment response to the generic equivalent agent OR
4. Patient has an FDA labeled contraindication to the generic equivalent agent

Medication subject to step therapy will be covered when the above criteria are met.