ATRIO Health Plans

2018 Step Therapy Requirements
PPO Plans

Effective: 11/1/2018

HPMS Approved Formulary File 18032

ANTIDEPRESSANTS

Products Affected

Step 2:

- TRINTELLIX 10 MG TABLET
- TRINTELLIX 20 MG TABLET
- TRINTELLIX 5 MG TABLET
- VIIBRYD 10 MG (7)-20 MG (23) TABLETS IN A DOSE PACK
- VIIBRYD 10 MG TABLET
- VIIBRYD 20 MG TABLET
- VIIBRYD 40 MG TABLET

Details

Criteria	PRIOR CLAIM FOR PAROXETINE, FLUOXETINE, SERTRALINE, DULOXETINE, CITALOPRAM, MIRTAZAPINE, ESCITALOPRAM, OR BUPROPION (IR, SR, XL) WITHIN THE PAST 120 DAYS.

ANTIDEPRESSANTS II

Products Affected

Step 2:

- FETZIMA 120 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 20 MG (2)-40 MG (26) CAPSULE,EXTENDED RELEASE,24 HR,DOSE PACK
- FETZIMA 20 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 40 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 80 MG CAPSULE,EXTENDED RELEASE

Details

Criteria	PRIOR CLAIM FOR TRINTELLIX AND VIIBRYD WITHIN THE PAST 365 DAYS.

ANTIDIABETIC AGENTS - MISCELLANEOUS

Products Affected

Step 2:

- GLYXAMBI 10 MG-5 MG TABLET
- GLYXAMBI 25 MG-5 MG TABLET
- INVOKAMET 150 MG-1,000 MG TABLET
- INVOKAMET 150 MG-500 MG TABLET
- INVOKAMET 50 MG-1,000 MG TABLET
- INVOKAMET 50 MG-500 MG TABLET
- INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE
- INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE
- INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE
- INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE
- INVOKANA 100 MG TABLET
- INVOKANA 300 MG TABLET
- JARDIANCE 10 MG TABLET
- JARDIANCE 25 MG TABLET
- SYNJARDY 12.5 MG-1,000 MG TABLET
- SYNJARDY 12.5 MG-500 MG TABLET
- SYNJARDY 5 MG-1,000 MG TABLET
- SYNJARDY 5 MG-500 MG TABLET
- SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE
- SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE
- SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE
- SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE

Details

Criteria	PRIOR CLAIM FOR METFORMIN, METFORMIN ER, A SULFONYLUREA AGENT (GLYBURIDE, GLIPIZIDE, GLIMEPIRIDE, TOLAZAMIDE, TOLBUTAMIDE), PIOGLITAZONE, COMBINATION OF A SULFONYLUREA-METFORMIN, PIOGLITAZONE-METFORMIN, OR PIOGLITAZONE-GLIMEPIRIDE WITHIN THE PAST 120 DAYS.

ANTI-INFLAMMATORY AGENTS - GI

Products Affected

Step 2:

- DIPENTUM 250 MG CAPSULE

Details

Criteria	PRIOR CLAIM FOR ANY 1 OF THE FOLLOWING: BALSALAZIDE, APRISO, DELZICOL, MESALAMINE DR 800 MG TAB, OR FORMULARY MESALAMINE 1.2 G DR TAB WITHIN THE PAST 120 DAYS.

ANTIPSYCHOTIC AGENTS

Products Affected

Step 2:

- *clozapine 100 mg disintegrating tablet*
- *clozapine 12.5 mg disintegrating tablet*
- *clozapine 150 mg disintegrating tablet*
- *clozapine 200 mg disintegrating tablet*
- *clozapine 25 mg disintegrating tablet*
- FANAPT 1 MG TABLET
- FANAPT 10 MG TABLET
- FANAPT 12 MG TABLET
- FANAPT 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLETS IN A DOSE PACK
- FANAPT 2 MG TABLET
- FANAPT 4 MG TABLET
- FANAPT 6 MG TABLET
- FANAPT 8 MG TABLET
- SAPHRIS 10 MG SUBLINGUAL TABLET
- SAPHRIS 2.5 MG SUBLINGUAL TABLET
- SAPHRIS 5 MG SUBLINGUAL TABLET
- VERSACLOZ 50 MG/ML ORAL SUSPENSION
- VRAYLAR 1.5 MG (1)-3 MG (6) CAPSULES IN A DOSE PACK
- VRAYLAR 1.5 MG CAPSULE
- VRAYLAR 3 MG CAPSULE
- VRAYLAR 4.5 MG CAPSULE
- VRAYLAR 6 MG CAPSULE

Details

Criteria	PRIOR CLAIM FOR FORMULARY VERSIONS OF ANY TWO ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE WITHIN THE PAST 365 DAYS.

ANTIPSYCHOTIC AGENTS II

Products Affected

Step 2:

- REXULTI 0.25 MG TABLET
- REXULTI 0.5 MG TABLET
- REXULTI 1 MG TABLET
- REXULTI 2 MG TABLET
- REXULTI 3 MG TABLET
- REXULTI 4 MG TABLET

Details

Criteria	PRIOR CLAIM FOR TWO (2) OF THE FOLLOWING FORMULARY ORAL VERSIONS OF ATYPICAL ANTIPSYCHOTICS (RISPERIDONE, CLOZAPINE, OLANZAPINE, QUETIAPINE, ARIPIPRAZOLE OR ZIPRASIDONE) OR SSRI (CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE OR SERTRALINE) OR SNRI (DESVENLAFAXINE, DULOXETINE OR VENLAFAXINE) WITHIN THE PAST 365 DAYS

ANTIULCER AGENTS

Products Affected

Step 2:

- DEXILANT 30 MG CAPSULE, DELAYED RELEASE
- DEXILANT 60 MG CAPSULE, DELAYED RELEASE
- *rabeprazole 20 mg tablet,delayed release*

Details

Criteria	PRIOR CLAIM FOR GENERIC FEDERAL LEGEND ORAL OMEPRAZOLE, PANTOPRAZOLE, OR LANSOPRAZOLE WITHIN THE PAST 120 DAYS.

B VERSUS D ADMINISTRATIVE STEP

Products Affected

Step 2:

- CYCLOPHOSPHAMIDE 25 MG CAPSULE
- CYCLOPHOSPHAMIDE 50 MG CAPSULE
- *methotrexate sodium 2.5 mg tablet*
- TREXALL 10 MG TABLET
- TREXALL 15 MG TABLET
- TREXALL 5 MG TABLET
- TREXALL 7.5 MG TABLET
- XATMEP 2.5 MG/ML ORAL SOLUTION

Details

Criteria	IN ORDER TO ASSIST IN A PART B VS. D PAYMENT DETERMINATION, A PRIOR CLAIM SEEN FOR A RHEUMATOID ARTHRITIS, PSORIASIS OR ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS DRUG WITHIN THE PAST 120 DAYS WILL QUALIFY FOR PART D PAYMENT. ALL OTHER INDICATIONS WILL HAVE A PART B VS. D PAYMENT DETERMINATION MADE THROUGH THE FORMULARY EXCEPTION PROCESS PRIOR TO THE APPROVAL OF THE DRUG.

BRONCHODILATOR

Products Affected

Step 2:

- VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER

Details

Criteria	PRIOR CLAIM FOR PROAIR HFA OR PROAIR RESPICLICK WITHIN THE PAST 120 DAYS.

ELUXADOLINE

Products Affected

Step 2:

- VIBERZI 100 MG TABLET
- VIBERZI 75 MG TABLET

Details

Criteria	PRIOR CLAIM FOR DICYCLOMINE AND XIFAXAN 550MG WITHIN THE PAST 365 DAYS.

ENALAPRIL ORAL SOLUTION

Products Affected

Step 2:

- EPANED 1 MG/ML ORAL SOLUTION

Details

Criteria	PRIOR CLAIM FOR GENERIC ENALAPRIL ORAL WITHIN THE PAST 120 DAYS.

FIDAXOMICIN

Products Affected

Step 2:

- DIFICID 200 MG TABLET

Details

Criteria	PRIOR CLAIM FOR 2 OF THE FOLLOWING (ONE FROM EACH GROUP): A) ORAL METRONIDAZOLE TABLETS AND B) VANCOMYCIN CAPSULES IN PAST 365 DAYS.

GABAPENTIN SR

Products Affected

Step 2:

- GRALISE 300 MG TABLET,EXTENDED RELEASE
- GRALISE 30-DAY STARTER PACK 300 MG (9)-600 MG (69) TABLET,EXT. RELEASE
- GRALISE 600 MG TABLET,EXTENDED RELEASE

Details

Criteria	PRIOR CLAIM FOR GABAPENTIN IMMEDIATE RELEASE WITHIN THE PAST 120 DAYS.

INSULIN- NPH

Products Affected

Step 2:

- HUMULIN N NPH U-100 INSULIN (ISOPHANE SUSP) 100 UNIT/ML SUBCUTANEOUS
- HUMULIN N NPH U-100 INSULIN KWIKPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS

Details

Criteria	PRIOR CLAIM FOR NOVOLIN N WITHIN THE PAST 120 DAYS.

INSULIN- RAPID ACTING

Products Affected

Step 2:

- HUMALOG JUNIOR KWIKPEN (U-100) 100 UNIT/ML SUBCUTANEOUS HALF-UNIT PEN
- HUMALOG KWIKPEN (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS
- HUMALOG KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS
- HUMALOG U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS CARTRIDGE
- HUMALOG U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION

Details

Criteria	PRIOR CLAIM FOR NOVOLOG OR FIASP WITHIN THE PAST 120 DAYS.

INSULIN- RAPID ACTING MIX

Products Affected

Step 2:

- HUMALOG MIX 50-50 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION
- HUMALOG MIX 50-50 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN
- HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION
- HUMALOG MIX 75-25 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN

Details

Criteria	PRIOR CLAIM FOR NOVOLOG MIX WITHIN THE PAST 120 DAYS.

INSULIN- REGULAR

Products Affected

Step 2:

- HUMULIN R REGULAR U-100 INSULIN 100 UNIT/ML INJECTION SOLUTION

Details

Criteria	PRIOR CLAIM FOR NOVOLIN R WITHIN THE PAST 120 DAYS.

INSULIN- REGULAR MIX

Products Affected

Step 2:

- HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION
- HUMULIN 70/30 U-100 INSULIN KWIKPEN 100 UNIT/ML SUBCUTANEOUS

Details

Criteria	PRIOR CLAIM FOR NOVOLIN MIX WITHIN THE PAST 120 DAYS.

INSULIN/GLP-1 ANALOG

Products Affected

Step 2:

- SOLIQUA 100/33 100 UNIT-33 MCG/ML SUBCUTANEOUS INSULIN PEN
- XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN

Details

Criteria	TRIAL OF 2 (1 FROM EACH):(1) VICTOZA, LANTUS, OZEMPIC OR TOUJEO AND(2)METFORMIN/ER, SULFONYLUREA-(SU) (GLYBURIDE, GLIPIZIDE, GLIMEPIRIDE), SU-MET, PIOGLITAZONE, PIO-MET, OR PIO-GLIMEPIR IN PAST YR.

LESINURAD

Products Affected

Step 2:

- ZURAMPIC 200 MG TABLET

Details

Criteria	PRIOR CLAIM FOR ULORIC OR ALLOPURINOL TABLETS WITHIN THE PAST 120 DAYS.

LISINOPRIL ORAL SOLUTION

Products Affected

Step 2:

- QBRELIS 1 MG/ML ORAL SOLUTION

Details

Criteria	PRIOR CLAIM FOR GENERIC LISINOPRIL WITHIN THE PAST 120 DAYS.

NOVEL ORAL ANTICOAGULANTS

Products Affected

Step 2:

- PRADAXA 110 MG CAPSULE
- PRADAXA 150 MG CAPSULE
- PRADAXA 75 MG CAPSULE

Details

Criteria	PRIOR CLAIM FOR ELIQUIS AND XARELTO IN THE PAST 365 DAYS.

OPHTHALMIC ANTIHISTAMINES

Products Affected

Step 2:

- ALREX 0.2 % EYE DROPS,SUSPENSION
- BEPREVE 1.5 % EYE DROPS

Details

Criteria	PRIOR CLAIM FOR ONE OF THE FOLLOWING: OTC LORATADINE, OTC LORATADINE D, OTC CETIRIZINE, OTC CETIRIZINE D, OTC FEXOFENADINE, OTC FEXOFENADINE D, OTC XYZAL, OTC GENERIC KETOTIFEN EYE DROPS 0.025%, LEVOCETIRIZINE, CROMOLYN SODIUM, EPINASTINE, OR FORMULARY OLOPATADINE EYE DROPS WITHIN THE PAST 120 DAYS.

OSMOLEX

Products Affected

Step 2:

- OSMOLEX ER 129 MG TABLET, EXTENDED RELEASE
- OSMOLEX ER 193 MG TABLET, EXTENDED RELEASE
- OSMOLEX ER 258 MG TABLET,

Details

Criteria	PRIOR CLAIM FOR AMANTADINE HCL IMMEDIATE RELEASE WITHIN THE PAST 120 DAYS.

RENIN ANGIOTENSIN SYSTEM INHIBITORS

Products Affected

Step 2:

- DIOVAN 160 MG TABLET
- DIOVAN 320 MG TABLET
- DIOVAN 40 MG TABLET
- DIOVAN 80 MG TABLET
- DIOVAN HCT 160 MG-12.5 MG TABLET
- DIOVAN HCT 160 MG-25 MG TABLET
- DIOVAN HCT 320 MG-12.5 MG TABLET
- DIOVAN HCT 320 MG-25 MG TABLET
- DIOVAN HCT 80 MG-12.5 MG TABLET
- TEKAMLO 150 MG-10 MG TABLET
- TEKAMLO 150 MG-5 MG TABLET
- TEKAMLO 300 MG-10 MG TABLET
- TEKAMLO 300 MG-5 MG TABLET
- TEKTURNA 150 MG TABLET
- TEKTURNA 300 MG TABLET
- TEKTURNA HCT 150 MG-12.5 MG TABLET
- TEKTURNA HCT 150 MG-25 MG TABLET
- TEKTURNA HCT 300 MG-12.5 MG TABLET
- TEKTURNA HCT 300 MG-25 MG TABLET

Details

Criteria	PRIOR CLAIM FOR AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE INHIBITOR), OR ACE INHIBITOR COMBINATION OR A GENERIC ANGIOTENSIN RECEPTOR BLOCKER (ARB), OR GENERIC ARB COMBINATION WITHIN THE PAST 120 DAYS.

SPRITAM

Products Affected

Step 2:

- SPRITAM 1,000 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 250 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 500 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 750 MG TABLET FOR ORAL SUSPENSION

Details

Criteria	PRIOR CLAIM FOR LEVETIRACETAM SOLUTION IN THE PAST 120 DAYS

ZARXIO

Products Affected

Step 2:

- ZARXIO 300 MCG/0.5 ML INJECTION SYRINGE
- ZARXIO 480 MCG/0.8 ML INJECTION SYRINGE

Details

Criteria	PRIOR CLAIM FOR NEUPOGEN WITHIN THE PAST 120 DAYS.

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