HEALTH CHOICE GENERATIONS (PDP)
2017 Step Therapy Criteria

ARISTADA

Products Affected

Step 2:

- Aristada 441 MG/1.6ML INTRAMUSCULAR*
- Aristada 662 MG/2.4ML INTRAMUSCULAR*
- Aristada 882 MG/3.2ML INTRAMUSCULAR*

Details

Criteria	Claim will pay automatically for ARISTADA if enrollee has a paid claim for at least a 1 days supply of ABILIFY MAINTENA and LATUDA in the past 365 days. Otherwise, ARISTADA requires a step therapy exception request indicating: (1) history of inadequate treatment response with ABILIFY MAINTENA and LATUDA, OR (2) history of adverse event with ABILIFY MAINTENA and LATUDA, OR (3) ABILIFY MAINTENA and LATUDA are contraindicated.

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AUBAGIO

Products Affected

Step 2:

- Aubagio TABLET 14 MG ORAL
- Aubagio TABLET 7 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Aubagio IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Gilenya or Tecfidera IN THE PAST 365 DAYS. OTHERWISE, Aubagio REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Gilenya or Tecfidera, OR (2) HISTORY OF ADVERSE EVENT WITH Gilenya or Tecfidera, OR (3) Gilenya or Tecfidera IS CONTRAINDICATED.

BPH

Products Affected

Step 2:

- Rapaflo CAPSULE 4 MG ORAL
- Rapaflo CAPSULE 8 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR RAPAFLO IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF ALFUZOSIN, DUTASTERIDE, DUTASTERIDE/TAMSULOSIN, FINASTERIDE OR TAMSULOSIN IN THE PAST 365 DAYS. OTHERWISE RAPAFLO REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH ALFUZOSIN, DUTASTERIDE, DUTASTERIDE/TAMSULOSIN, FINASTERIDE OR TAMSULOSIN, OR (2) HISTORY OF ADVERSE EVENT WITH ALFUZOSIN, DUTASTERIDE, DUTASTERIDE/TAMSULOSIN, FINASTERIDE OR TAMSULOSIN, OR (3) ALFUZOSIN, DUTASTERIDE, DUTASTERIDE/TAMSULOSIN, FINASTERIDE OR TAMSULOSIN IS CONTRAINDICATED.

BYSTOLIC

Products Affected

Step 2:

- Bystolic TABLET 10 MG ORAL
- Bystolic TABLET 2.5 MG ORAL
- Bystolic TABLET 20 MG ORAL
- Bystolic TABLET 5 MG ORAL

Details

Criteria	Claim will pay automatically for Bystolic if enrollee has a paid claim for at least a 1 days supply of any 1 generic formulary beta-blocker in the past 365 days. Otherwise, Bystolic requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 1 generic formulary beta-blocker, OR (2) history of adverse event with any 1 generic formulary beta-blocker, OR (3) any 1 generic formulary beta-blocker are 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.

LONG ACTING FENTANYL

Products Affected

Step 2:

- FentaNYL PATCH 72 HR 100 MCG/HR TRANSDERMAL
- FentaNYL PATCH 72 HR 25 MCG/HR TRANSDERMAL
- FentaNYL PATCH 72 HR 37.5 MCG/HR TRANSDERMAL
- FentaNYL PATCH 72 HR 50 MCG/HR TRANSDERMAL
- FentaNYL PATCH 72 HR 62.5 MCG/HR TRANSDERMAL
- FentaNYL PATCH 72 HR 75 MCG/HR TRANSDERMAL
- FentaNYL PATCH 72 HR 87.5 MCG/HR TRANSDERMAL

Details

Criteria	Claim will pay automatically for Fentanyl patches if enrollee has paid claims history for both Group A and Group B drugs. GROUP A Drugs: Any 1 days supply in the past 365 days of brand Opana ER or generic Oxymorphone ER (2) GROUP B Drugs: Any 1 days supply in the past 365 days of either Morphine ER or Methadone. Otherwise, the drug requires a step therapy exception request indicating any ONE of the following: (1) history of inadequate treatment response with Group A or Group B drugs, OR (2) history of adverse event with Group A or Group B drugs, OR (3) Group A or Group B drugs are contraindicated.

OVERACTIVE BLADDER

Products Affected

Step 2:

- Myrbetriq TABLET EXTENDED RELEASE 24 HR* 25 MG ORAL
- Myrbetriq TABLET EXTENDED RELEASE 24 HR* 50 MG ORAL
- VESIcare TABLET 10 MG ORAL
- VESIcare TABLET 5 MG ORAL

Details

Criteria	Claim will pay automatically for Myrbetriq or Vesicare if enrollee has a paid claim for at least a 1 days supply of any formulary urinary anticholinergic in the past 365 days. Otherwise, Myrbetriq or Vesicare requires a step therapy exception request indicating: (1) history of inadequate treatment response with formulary urinary anticholinergic, OR (2) history of adverse event with formulary urinary anticholinergic, OR (3) formulary urinary anticholinergic is contraindicated.

PRADAXA

Products Affected

Step 2:

- Pradaxa CAPSULE 110 MG ORAL
- Pradaxa CAPSULE 150 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Pradaxa IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Xarelto or Eliquis IN THE PAST 365 DAYS. OTHERWISE, Pradaxa REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Xarelto or Eliquis, OR (2) HISTORY OF ADVERSE EVENT WITH Xarelto or Eliquis, OR (3) Xarelto or Eliquis IS CONTRAINDICATED.

PROLIA

Products Affected

Step 2:

- Prolia SOLUTION 60 MG/ML SUBCUTANEOUS*

Details

Criteria	Claim will pay automatically for Prolia if enrollee has a paid claim for at least a 1 days supply of any 2 generic formulary bisphosphonates in the past 180 days. Otherwise, Prolia requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 2 generic formulary bisphosphonates , OR (2) history of adverse event with any 2 generic formulary bisphosphonates, OR (3) any 2 generic formulary bisphosphonates are contraindicated. For osteoporosis prophylaxis in men at high risk for bone fractures after receiving androgen deprivation therapy for nonmetastatic prostate cancer and in women at high risk for bone fractures after receiving adjuvant aromatase inhibitor therapy for breast cancer, Prolia will be approved.

RELPAX

Products Affected

Step 2:

- Relpax TABLET 20 MG ORAL
- Relpax TABLET 40 MG ORAL

Details

Criteria	Claim will pay automatically for Relpax if enrollee has a paid claim for at least a 1 days supply of any formulary triptan (selective serotonin receptor agonist) in the past 365 days. Otherwise, Relpax requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary triptan (selective serotonin receptor agonist), OR (2) history of adverse event with any formulary triptan (selective serotonin receptor agonist), OR (3) any formulary triptan (selective serotonin receptor agonist) is contraindicated.

RHEUMATOID ARTHRITIS

Products Affected

Step 2:

- Actemra 162 MG/0.9ML SUBCUTANEOUS*
- Actemra SOLUTION 200 MG/10ML INTRAVENOUS*
- Actemra SOLUTION 400 MG/20ML INTRAVENOUS*
- Actemra SOLUTION 80 MG/4ML INTRAVENOUS*
- Cimzia KIT 2 X 200 MG SUBCUTANEOUS*
- Cimzia Prefilled KIT 2 X 200 MG/ML SUBCUTANEOUS*
- Kineret 100 MG/0.67ML SUBCUTANEOUS*
- Orencia 125 MG/ML SUBCUTANEOUS*
- Orencia ClickJect 125 MG/ML SUBCUTANEOUS*
- Orencia SOLUTION RECONSTITUTED 250 MG INTRAVENOUS*
- Simponi 100 MG/ML SUBCUTANEOUS*
- Simponi 50 MG/0.5ML SUBCUTANEOUS*
- Simponi Aria SOLUTION 50 MG/4ML INTRAVENOUS*
- Stelara 45 MG/0.5ML SUBCUTANEOUS*
- Xeljanz TABLET 5 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR THE REQUESTED DRUG (ACTEMRA, XELJANZ, STELARA, CIMZIA, SIMPONI, SIMPONI ARIA, ORENCIA OR KINERET) IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF HUMIRA AND ENBREL IN THE PAST 120 DAYS. OTHERWISE, THE REQUESTED DRUG REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH HUMIRA AND ENBREL, OR (2) HISTORY OF ADVERSE EVENT WITH HUMIRA AND ENBREL, OR (3) HUMIRA AND ENBREL ARE CONTRAINDICATED. FOR DIAGNOSIS OF CROHN'S DISEASE, CIMZIA WILL BE APPROVED AFTER TRIAL OF HUMIRA. FOR ULCERATIVE COLITIS, SIMPONI WILL BE APPROVED AFTER TRIAL OF HUMIRA. FOR CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES KINERET WILL BE APPROVED WITHOUT TRIAL OF HUMIRA AND/OR ENBREL.

TRINTELLIX

Products Affected

Step 2:

- Trintellix TABLET 10 MG ORAL
- Trintellix TABLET 20 MG ORAL
- Trintellix TABLET 5 MG ORAL

Details

Criteria	Claim will pay automatically for trintellix if enrollee has a paid claim for at least a 1 days supply of any 2 generic formulary antidepressants in the past 365 days. Otherwise, trintellix requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 2 generic formulary antidepressants, OR (2) history of adverse event with any 2 generic formulary antidepressants, OR (3) any 2 generic formulary antidepressants are contraindicated.

UCERIS

Products Affected

Step 2:

- Uceris FOAM 2 MG/ACT
- Uceris TABLET EXTENDED RELEASE 24 HR* 9 MG ORAL

Details

Criteria	Claim will pay automatically for Uceris if enrollee has a paid claim for at least a 1 days supply of any formulary corticosteroid used to treat ulcerative colitis in the past 365 days. Otherwise, Uceris requires a step therapy exception request indicating: (1) history of inadequate treatment response with formulary corticosteroid used to treat ulcerative colitis, OR (2) history of adverse event with formulary corticosteroid used to treat ulcerative colitis, OR (3) formulary corticosteroid used to treat ulcerative colitis 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 past 365 days. 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.

VRAYLAR

Products Affected

Step 2:

- Vraylar 1.5 & 3 MG ORAL
- Vraylar CAPSULE 1.5 MG ORAL
- Vraylar CAPSULE 3 MG ORAL
- Vraylar CAPSULE 4.5 MG ORAL
- Vraylar CAPSULE 6 MG ORAL

Details

Criteria	Claim will pay automatically for VRAYLAR if enrollee has a paid claim for at least a 1 days supply of ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, SEROQUEL XR, ZIPRASIDONE, or LATUDA in the past 365 days. Otherwise, Vraylar requires a step therapy exception request indicating any ONE of criteria 1, 2, 3, or 4: (1) history of inadequate treatment response with ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, SEROQUEL XR, ZIPRASIDONE, or LATUDA or (2) history of adverse event with ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, SEROQUEL XR, ZIPRASIDONE, or LATUDA or (3) ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, SEROQUEL XR, ZIPRASIDONE, or LATUDA are contraindicated or (4) For diagnosis of MANIC EPISODES ASSOCIATED WITH BIPOLAR DISORDER, THE COVERAGE DETERMINATION WILL BE APPROVED WITHOUT REQUIREMENT OF TRIAL AND FAILURE OR CONTRAINDICATION TO LATUDA.

XTANDI

Products Affected

Step 2:

- Xtandi CAPSULE 40 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR XTANDI IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF ZYTIGA IN THE PAST 365 DAYS. OTHERWISE, XTANDI REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH ZYTIGA, OR (2) HISTORY OF ADVERSE EVENT WITH ZYTIGA, OR (3) ZYTIGA IS CONTRAINDICATED.

HEALTH CHOICE GENERATIONS (PDP)
2017 Step Therapy Criteria

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