

## **PPI ST - NEXIUM**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

NEXIUM DR 10 MG PACKET, NEXIUM DR 20 MG CAPSULE, NEXIUM DR 20 MG PACKET, NEXIUM DR 40 MG CAPSULE, NEXIUM DR 40 MG PACKET

### **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.

## **PPI ST - PREVACID**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

PREVACID DR 30 MG CAPSULE

### **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.

## **PPI ST - PROTONIX**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

PROTONIX DR 20 MG TABLET, PROTONIX DR 40 MG 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.

## STATINS ST - CRESTOR

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

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.

## STATINS ST - LIPITOR

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

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.

## STATINS ST - VYTORIN

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

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.

## **STATINS ST - ZOCOR**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

ZOCOR 10 MG TABLET, ZOCOR 20 MG TABLET, ZOCOR 40 MG 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.

## **TRIPTANS ST - IMITREX INJECTABLE**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

IMITREX 4 MG/0.5 ML CARTRIDGES, IMITREX 4 MG/0.5 ML PEN INJECT

### **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.



## **TRIPTANS ST - IMITREX NASAL SPRAY**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

IMITREX 20 MG NASAL SPRAY, IMITREX 5 MG NASAL SPRAY

### **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.

## **TRIPTANS ST - IMITREX TABLET**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

IMITREX 100 MG TABLET, IMITREX 25 MG TABLET, IMITREX 50 MG 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.

## **TRIPTANS ST - MAXALT**

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

MAXALT, MAXALT MLT 10 MG 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.

## URINARY INCONTINENCE ST - DETROL

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

DETROL

### **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.

## URINARY INCONTINENCE ST - DETROL LA

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

DETROL LA

### **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.

## URINARY INCONTINENCE ST - TOVIAZ

---

### **MEDICATION(S) SUBJECT TO STEP THERAPY**

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.