ORAL INHALERS ST - SPIRIVA HANDIHALER

MEDICATION(S) SUBJECT TO STEP THERAPY

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.

PPI ST - NEXIUM

MEDICATION(S) SUBJECT TO STEP THERAPY

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.

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

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 - 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.