MASS ADVANTAGE

2024

Step Therapy Requirements

For members in the following plans:

Mass Advantage Basic (HMO)

Mass Advantage Plus (HMO)

Mass Advantage Premiere (PPO)

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.