

## **Step Therapy Criteria**

**Step Therapy Group**

**Drug Names**

**Step Therapy Criteria**

BISPHOSPHONATES

FOSAMAX PLUS D

Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).

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ESOMEPRAZOLE

ESOMEPRAZOLE MAGNESIUM

Coverage will be provided if two of the following generic alternatives: omeprazole capsules, pantoprazole tablets, or lansoprazole capsules have been tried (at least a 30 day supply in the prior 180 days).

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HMG-COA INHIBITORS

ALTOPREV, LIVALO, ZYPITAMAG

Coverage will be provided if atorvastatin, ezetimibe/simvastatin, fluvastatin, fluvastatin extended-release, lovastatin, pravastatin, rosuvastatin, simvastatin tablets, or amlodipine/atorvastatin has been tried (at least a 30 day supply in the prior 180 days).

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URINARY ANTISPASMODICS

TOLTERODINE TARTRATE, TOLTERODINE TARTRATE ER

Coverage will be provided if oxybutynin, oxybutynin extended-release, fesoterodine, trospium immediate-release or mirabegron has been tried (at least a 30 day supply in the prior 180 days).