2023

# Part D Step Therapy Criteria

PREMERA BLUE CROSS MEDICARE ADVANTAGE HMO PLANS

- Premera Blue Cross Medicare Advantage **HMO**
- Premera Blue Cross Medicare Advantage **Classic (HMO)**
- Premera Blue Cross Medicare Advantage **Total Health (HMO)**
- Premera Blue Cross Medicare Advantage **Peak + Rx (HMO)**
- Premera Blue Cross Medicare Advantage **Sound + Rx (HMO)**

For more recent information or other questions, please contact Premera Blue Cross Medicare Advantage at **888-850-8526 (TTY/TDD: 711)** October 1–March 31, 8 a.m. to 8 p.m., 7 days a week April 1–September 30, 8 a.m. to 8 p.m., Monday through Friday.

Calls to this number are free. Customer Service also has free interpreter services available for non-English speakers.

premera.com/ma

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Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on contract renewal.

# Step Therapy Criteria

***Step Therapy Group*** BENIGN PROSTATIC HYPERPLASIA
***Drug Names*** CARDURA XL
***Step Therapy Criteria*** Coverage will be provided if terazosin, alfuzosin, doxazosin, silodosin or tamsulosin has been tried (at least a 30 day supply in the prior 180 days).

***Step Therapy Group*** BISPHOSPHONATES
***Drug Names*** BINOSTO, FOSAMAX PLUS D
***Step Therapy Criteria*** Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).

***Step Therapy Group*** DPP4 INHIBITORS
***Drug Names*** ALOGLIPTIN, ALOGLIPTIN/METFORMIN HCL, ALOGLIPTIN/METFORMIN HYDR, ALOGLIPTIN/PIOGLITAZONE, KOMBIGLYZE XR, ONGLYZA
***Step Therapy Criteria*** Coverage will be provided if the patient had a trial of at least a 30 day supply each of sitagliptin (Januvia [sitagliptin], Janumet [sitagliptin/metformin hydrochloride], or Janumet XR [sitagliptin/metformin hydrochloride extended-release]) AND linagliptin (Tradjenta [linagliptin], Jentadueto [linagliptin/metformin hydrochloride], or Jentadueto XR [linagliptin/metformin hydrochloride extended-release]) in the prior 180 days.

***Step Therapy Group*** HMG-COA INHIBITORS
***Drug Names*** ALTOPREV, EZALLOR SPRINKLE, FLOLIPID, LIVALO, ZYPITAMAG
***Step Therapy Criteria*** Coverage will be provided if atorvastatin, ezetimibe/simvastatin, fluvastatin, fluvastatin extended-release, lovastatin, pravastatin, rosuvastatin tablets, simvastatin tablets, or amlodipine/atorvastatin has been tried (at least a 30-day supply) in the prior 180 days.

***Step Therapy Group*** LEVALBUTEROL
***Drug Names*** LEVALBUTEROL TARTRATE HFA
***Step Therapy Criteria*** Coverage will be provided if albuterol HFA or Ventolin HFA have been tried (at least a 30-day supply) in the prior 180 days.

***Step Therapy Group*** LEVOTHYROXINE CAP
***Drug Names*** LEVOTHYROXINE SODIUM
***Step Therapy Criteria*** Coverage will be provided if levothyroxine tablets have been tried (at least a 30 day supply in the prior 180 days).

***Step Therapy Group*** NASAL STEROIDS
***Drug Names*** BECONASE AQ, MOMETASONE FUROATE, OMNARIS, QNASL, QNASL CHILDRENS, ZETONNA
***Step Therapy Criteria*** Coverage will be provided if generic fluticasone nasal spray has been tried (at least a 30-day supply) in the prior 180 days.

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| ***Step Therapy Group*** | PPI |
| ***Drug Names*** | ESOMEPRAZOLE MAGNESIUM, LANSOPRAZOLE, PANTOPRAZOLE SODIUM |
| ***Step Therapy Criteria*** | 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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| ***Step Therapy Group*** | PROSTAGLANDINS |
| ***Drug Names*** | XELPROS, ZIOPTAN |
| ***Step Therapy Criteria*** | Coverage will be provided if latanoprost, bimatoprost, or travoprost has been tried (at least a 30-day supply) in the prior 180 days. |

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| ***Step Therapy Group*** | RYTARY |
| ***Drug Names*** | RYTARY |
| ***Step Therapy Criteria*** | Coverage will be provided if a generic immediate-release or extended-release carbidopa-levodopa containing product has been tried for at least 30 days in the prior 180 days. |

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| ***Step Therapy Group*** | TRIPTANS |
| ***Drug Names*** | ONZETRA XSAIL, TOSYMRA, ZEMBRACE SYMTOUCH |
| ***Step Therapy Criteria*** | Coverage will be provided if almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, rizatriptan ODT, sumatriptan nasal spray, sumatriptan tabs, sumatriptan injection, zolmitriptan tabs, OR zolmitriptan ODT has been tried (at least a 30 day supply in the prior 180 days). |

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| ***Step Therapy Group*** | URINARY ANTISPASMODICS |
| ***Drug Names*** | DARIFENACIN HYDROBROMIDE, GELNIQUE, OXYTROL, TOLTERODINE TARTRATE ER |
| ***Step Therapy Criteria*** | Coverage will be provided if fesoterodine, mirabegron, oxybutynin, oxybutynin extended-release, solifenacin tablets, tolterodine tablets, trospium immediate-release, or vibegron has been tried (at least a 30-day supply in the prior 180 days). |