

## **Step Therapy Criteria**

<b>Step Therapy Group</b>	BENIGN PROSTATIC HYPERPLASIA
<b>Drug Names</b>	CARDURA XL, RAPAFLO
<b>Step Therapy Criteria</b>	Coverage will be provided if terazosin, alfuzosin, doxazosin or tamsulosin has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	BISPHOSPHONATES
<b>Drug Names</b>	BINOSTO, FOSAMAX PLUS D
<b>Step Therapy Criteria</b>	Coverage will be provided if alendronate, ibandronate, pamidronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	HMG-COA INHIBITORS
<b>Drug Names</b>	ALTOPREV, LIVALO, ZYPITAMAG
<b>Step Therapy Criteria</b>	Coverage will be provided if atorvastatin, fluvastatin, fluvastatin extended-release, lovastatin, pravastatin, simvastatin, rosuvastatin, or amlodipine/atorvastatin has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	PROSTAGLANDINS
<b>Drug Names</b>	VYZULTA, ZIOPTAN
<b>Step Therapy Criteria</b>	Coverage will be provided if latanoprost, bimatoprost, or travoprost has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	TRIPTANS
<b>Drug Names</b>	ONZETRA XSAIL, SUMAVEL DOSEPRO, TREXIMET, ZEMBRACE SYMTOUCH, ZOMIG
<b>Step Therapy Criteria</b>	Coverage will be provided if almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, rizatriptan ODT, sumatriptan nasal spray, sumatriptan tabs, sumatriptan injection, zolmitriptan OR zolmitriptan ODT has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	ULORIC
<b>Drug Names</b>	DUZALLO, ULORIC
<b>Step Therapy Criteria</b>	Coverage will be provided if allopurinol has been tried (at least a 30-day supply in the prior 180 days)

**Step Therapy Group**  
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URINARY ANTISPASMODICS

GELNIQUE, OXYTROL

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