

# STEP THERAPY PROGRAM



MEDICAL ASSOCIATES  
HEALTH PLANS®

## MEDICAL ASSOCIATES HEALTH PLANS

(For closed formulary groups)

Medical Associates Health Plans, in conjunction with MedImpact, provides management of your pharmacy benefits. Step Therapy programs are being implemented to ensure that you receive the most cost effective, covered medications to treat your condition.

### What is a step edit?

If a medication listed on the formulary has a step edit (ST), it means that another drug needs to be tried first prior to the listed drug being covered. Sometimes the step edits are automatic in the system, and sometimes the doctor needs to make a special request on your behalf.

Medications are an important part of the treatment plan for many medical conditions and should be taken under the direction of your physician. If you have any questions about the information in this handout, please contact our Pharmacy Case Managers at 563-584-4859 or 1-800-325-7442. For specific benefit limitations, please refer to your Plan Document for benefit coverage.

### Member Guidelines

The Step Therapy Programs are being implemented to ensure that you receive the most cost effective covered medications as early as possible in your treatment plan. **Provide this to your physician to inform him/her of your Step Therapy Program guidelines.**

### Physician Guidelines

Failure of previous steps in the Step Therapy Program:

- For most therapies, MedImpact will review the most recent 120 days of claim history available (**OR**)
- Contact Medical Associates Health Plans at 563-584-4859 or 800-325-7442.

*Note: Step Therapy Guidelines may be updated on an ongoing basis due to changes implemented by the Medical Associates Pharmacy & Therapeutics Committee.*

## STEP THERAPY DRUG CATEGORIES

### SINGULAIR (ASTHMA)

(Nasal Corticosteroids)

**STEP 1:** Approved for all members:  
flunisolide  
fluticasone propionate  
mometasone furoate

**STEP 2:** Only after failure with Step 1 medication.  
Singulair

**Note:** May do prior authorization for members under age 5. May do prior authorization for diagnosis of Asthma or Allergic Rhinitis (seasonal). Member must have used nasal corticosteroid AND a non-sedating antihistamine/decongestant combination within 120 days of prescription fill date for Leukotriene medication.

### PROTON PUMP INHIBITORS (PPIs)

**STEP 1:** Approved for all members:  
omeprazole

**STEP 2:** Only after failure with step 1 medication:  
Dexilant

**Note:** Brand omeprazole suspension ("First") will be allowed for children ages 12 or younger. Children ages 12 or younger will be allowed lansoprazole rapid release. This Step does not apply to members being treated with Plavix within last 120 days.

### SSRI

**STEP 1:** Approved for all members:  
Any generic SSRI  
fluoxetine  
fluvoxamine  
citalopram  
paroxetine  
sertraline

**STEP 2:** Only after failure with Step 1 medication.  
Lexapro

**Note:** This excludes children 18 years of age or younger.

# STEP THERAPY DRUG CATEGORIES

## TEKTURNA (HIGH BLOOD PRESSURE)

**STEP 1:** Approved for all members:  
Any generic ACE inhibitor or ACE combination:

benazepril  
captopril  
enalapril  
fosinopril  
lisinopril  
moexipril  
quinapril  
ramipril  
trandolapril

ACE Inhibitor/Thiazide combination:

fosinopril/HCTZ  
benazepril/HCTZ  
captopril/HCTZ  
enalapril/HCTZ  
lisinopril/HCTZ  
moexipril/HCTZ

ACE Inhibitor/CCB combination:

benazepril/amlodipine

**STEP 2:** Only after failure with step 1 medication.  
Tekturna

**Note:** A trial of an ACE Inhibitor/ACE Inhibitor combo product is not required if the member has tried an ARB or ARB combination product within 120 days:

- Angiotensin Receptor Blockers (ARBs): irbesartan, losartan, valsartan, candesartan, atacand, telmisartan, eprosartan, olmesartan.
- ARB/Thiazide combo products: losartan/HCTZ, valsartan/HCTZ, irbesartan/HCTZ, candesartan/HCTZ, telmisartan HCTZ, eprosartan/HCTZ, olmesartan/HCTZ

## COX-1 SPARING NSAIDS (ANTI-INFLAMMATORY)

**STEP 1:** Member must have tried OTC ibuprofen, naproxen, ketoprofen, aspirin

**STEP 2:** (Require prior authorization)  
Only after failure with two different first line NSAIDS within 120 days. Any generic NSAID: indomethacin, piroxicam, diclofenac, sulindac, tolmetin, meclofenamate, etodolac, fenoprofen, meloxicam

**STEP 3:** (Require prior authorization)  
Only after failure with at least two step 2 medications prescribed by a physician within 120 days.  
Celebrex  
oxaprozin  
nabumetone  
diclofenac sodium/misoprostol

**Note:** Celebrex is covered for members without step therapy if their prescription history/demographics reflect any of the following criteria in the last 12 months: age 65 or older, concurrent treatment with warfarin or other related anticoagulants, concurrent treatment with oral corticosteroids, or recent/concurrent treatment with Antineoplastic.

## BIPHOSPHONATES (OSTEOPOROSIS)

**STEP 1:** Approved for all members:  
generic alendronate

**STEP 2:** Only after failure with step 1 medication:  
Actonel with calcium  
Prolia  
Actonel

**Note:** For coverage of IV Reclast, the member must have a medical diagnosis that contributes to inability to use the oral medications such as inflammatory bowel disease, active gastric ulcer disease, esophageal stricture, etc., or other contraindications to the use of oral medications.

Forteo is a formulary medication whose use is reserved for treating women at high risk of fracture, including those with a very low BMD (T-score worse than 3.0 with a prior fragility fracture). This is based on the 2006 position statement from the North American Menopause Society (NAMS). Forteo requires prior authorization.

Prolia is a formulary medication, for the member who is post menopausal with osteoporosis at high risk for fracture who has tried alendromate/ Fosamax OR has significant renal failure where treatment of biphosphonate is not indicated.

## HYPNOTICS (SLEEP AGENTS)

**STEP 1:** Approved for all members:  
generic zolpidem  
generic temazepam  
generic flurazepam

**STEP 2:** Only after failure with step 1 medication.  
Sonata

**Note:** Sonata will process without prior authorization if member has prescription written by psychiatry providers, with other psychiatric medications.

## INTRANASAL STEROIDS

**STEP 1:** Approved for all members:  
generic flunisolide  
generic fluticasone

**STEP 2:** Only after failure with step 1 medication.  
Nasonex

# STEP THERAPY DRUG CATEGORIES

## STATINS (HIGH CHOLESTEROL)

**STEP 1:** Approved for all members:  
pravastatin  
lovastatin  
simvastatin

**STEP 2:** Only after failure with step 1 medication:  
Crestor  
Vytorin

**Note:** If the member is beginning therapy with a statin, the member's benefit will only cover a generic statin. Step 2 drugs will be approved only after member has tried/failed a 30-day supply of a generic statin, or if treating physician/provider offers additional information for special consideration of member's needs.

## BPH (BENIGN PROSTATIC HYPERPLASIA)

**STEP 1:** Approved for all members:  
Cardura (doxazosin)  
Hytrin (terazosin)

**STEP 2:** Only after failure with step 1 medication:  
Uroxatral (alfuzosin hcl)  
Proscar (finasteride)

**Note:** Members who are on cardiac or blood pressure medications may qualify for a prior authorization of Flomax if physician feels the other alpha blockers are too risky to use. If enlargement of prostate is present, Step 1 can be overridden by Health Care Services.

## CHANTIX (SMOKING CESSATION)

Please note zero copay applies (*Health Care Reform*):

**STEP 1:** Approved for all members:  
Zyban (bupropion)  
Nicotine gum  
Nicotine lozenge  
Nicotine inhaler  
Nicotine nasal spray  
Nicotine patch

**STEP 2:** Only after failure with step 1 medication:  
Chantix

**Note:** For Chantix, members should only take two 12-week therapies. It should either be a full 333 tablets total allowed, or 24 weeks/168 days allowed. A confirmation that member is continuing on Chantix after first 12 weeks is required. Prior authorization is required for second 12 weeks of therapy.

## JANUVIA (ORAL DIABETES MEDICINE)

**STEP 1:** Approved for all members:  
metformin  
sulfonylureas (glipizide)  
insulin  
glucovance

**STEP 2:** Only after failure with step 1 medication:  
Byetta (exenatide)  
Actos (Pioglitazone)

**Other Treatment:**  
(Require prior authorization)  
Januvia (Sitagliptan), Janumet, Janumet XR  
Cycloset  
Komniglyze

**Note:** Indications for use of Januvia: 1. Patients who are intolerant of sulfonylurea due to severe hypoglycemia or who are allergic to Metformin and/or sulfonylureas. 2. Added onto maximal therapy with Metformin and sulfonylurea if patients are near enough to A1c goal that an improvement of 0.6 to 0.9 is enough to achieve goal. (If A1c is greater than 1.5 above goal, Januvia (sitagliptan) would NOT be sufficient to achieve goal A1c.

## PARKINSON'S STEP THERAPY

**STEP 1:** Approved for all members:  
Selegiline

**STEP 2:** Only after failure with step 1 medication:  
Azilect