

Step Therapy

The ClearScript Step Therapy program promotes the cost-effective use of medications when more than one drug is available to treat a medical condition.

What is Step Therapy?

If you are taking a medication in the Step Therapy program, you are required to try one or more first step drugs before a second step drug is considered for coverage. Talk with your physician about which first step medication might be a good choice for you. A review may be required before a second step drug is covered.

If you have questions about the Step Therapy Program, contact ClearScript Member Services at the number on the back of your ID Card.

Important Note: The drugs included on this list may not be covered by all benefit plans. Your benefit plan determines coverage for all medications. Additional coverage restrictions may apply for the medications included on this list. This list is subject to change throughout the year.

Condition / Drug Class	First Step Drugs	Second Step Drugs
Asthma/COPD - Long-Acting Combo Inhalers	History of TWO of the following generics or preferred brands: ADVAIR DISKUS/HFA, BREO ELLIPTA, fluticasone-salmeterol OR SYMBICORT. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	AIRDUO DIGIHALER AIRDUO RESPICLICK
	Patient is 5 years of age with a trial and failure or intolerance to ONE fluticasone-salmeterol containing product OR patient is 6 years of age or older with a trial and failure or intolerance to any TWO of the following generics or preferred brands: ADVAIR DISKUS/HFA, BREO ELLIPTA, fluticasone-salmeterol OR SYMBICORT. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	DULERA
Asthma/COPD - Long-Acting Inhalers	History of the following preferred brand: SPIRIVA	INCRUSE ELLIPTA SEEBRI NEOHALER TUDORZA PRESSAIR

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
Asthma/COPD - Steroid Inhalers	<p>History of TWO of the following: ARNUITY ELLIPTA, FLOVENT DISKUS/HFA, PULMICORT FLEXHALER, QVAR, OR QVAR REDIHALER</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	ALVESCO ARMONAIR DIGIHALER ARMONAIR RESPICLICK ASMANEX ASMANEX HFA
Attention Disorder - Stimulants	<p>History of TWO of the following: amphetamine-dextroamphetamine, dexamethylphenidate, dextroamphetamine, methylphenidate, OR VYVANSE.</p>	ADDERALL ADDERALL XR ADHANSIA XR ADZENYS ER amphetamine amphetamine sulfate APTENSIO XR CONCERTA DAYTRANA DESOXYN DYANAVEL XR EVEKEO EVEKEO ODT FOCALIN FOCALIN XR JORNAY PM KAPVAY methamphetamine hcl METHYLIN methylphenidate er MYDAYIS procentra QUILLICHEW ER QUILLIVANT XR RITALIN RITALIN LA ZENZEDI zenedi
Cystic Fibrosis - Inhaled Tobramycin	<p>Trial and failure or intolerance of the following generic or preferred brand: tobramycin 300 mg/4 ml ampule or BETHKIS.</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	KITABIS PAK TOBI tobramycin

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
Diabetes - Blood Glucose Meters	<p>History of one of the following preferred brand of blood glucose meters: CONTOUR NEXT EZ METER, CONTOUR NEXT LINK METER, CONTOUR NEXT LINK 2.4 METER.</p> <p>Note: Exceptions may apply. Please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>All non-preferred brands and generics of blood glucose meters.</p>
Diabetes - Blood Glucose Test Strips	<p>History of the following preferred brand of blood glucose test strips: CONTOUR.</p> <p>Note: Exceptions may apply. Please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>All non-preferred brands and generics of blood glucose test strips.</p>
Diabetic Medications	<p>History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, or pioglitazone-metformin AND ONE of the following: BYETTA, BYDUREON OR BYDUREON BCISE AND ONE of the following: OZEMPIC, RYBELSUS, TRULICITY OR VICTOZA</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>ADLYXIN</p>
	<p>History of TWO of the following: HUMALOG (insulin lispro), NOVOLOG (insulin aspart), or LYUMJEV (insulin lispro).</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>ADMELOG ADMELOG SOLOSTAR APIDRA APIDRA SOLOSTAR FIASP FIASP FLEXTOUCH FIASP PENFILL INSULIN ASPART INSULIN ASPART FLEXPEN INSULIN ASPART PENFILL INSULIN ASPART PROT- INSULN ASP INSULIN LISPRO INSULIN LISPRO JUNIOR KWIKPEN INSULIN LISPRO KWIKPEN U-100 INSULIN LISPRO PROTAMINE MIX</p>

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
Diabetic Medications	<p>History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin AND ONE of the following: JANUMET, JANUMET XR, JANUVIA AND ONE of the following preferred brands: JENTADUETO, JENTADUETO XR, OR TRADJENTA.</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>alogliptin alogliptin-metformin alogliptin-pioglitazone KAZANO KOMBIGLYZE XR NESINA ONGLYZA OSENI</p>
	<p>History of TWO of the following: LANTUS, LEVEMIR, TRESIBA AND TOUJEO.</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>BASAGLAR KWIKPEN U-100 SEMGLEE SEMGLEE PEN</p>
	<p>Any one of the following generics: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>BYDUREON BYDUREON BCISE BYDUREON PEN BYETTA OZEMPIC RYBELSUS TRULICITY VICTOZA 2-PAK VICTOZA 3-PAK</p>
	<p>History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, OR pioglitazone-metformin OR ONE of the following: captopril, enalapril, lisinopril, quinapril, ramipril, fosinopril,trandolapril, perindopril, candesartan, valsartan, losartan, bisoprolol, carvedilol, carvedilol ER, metoprolol ER, spironolactone, OR eplerenone</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>FARXIGA</p>
	<p>History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, OR pioglitazone-metformin</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>GLYXAMBI JARDIANCE SYNJARDY SYNJARDY XR TRIJARDY XR XIGDUO XR</p>

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
Diabetic Medications	<p>History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, OR pioglitazone-metformin AND ONE of the following: FARXIGA, XIGDUO XR AND ONE of the following: GLYXAMBI, SYNJARDY, SYNJARDY XR, TRIJARDY XR OR JARDIANCE.</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>INVOKAMET INVOKAMET XR INVOKANA QTERN SEGLUROMET STEGLATRO STEGLUJAN</p>
	<p>History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, OR pioglitazone-metformin.</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>JANUMET JANUMET XR JANUVIA JENTADUETO JENTADUETO XR TRADJENTA</p>
Epinephrine Auto-Injectors	<p>Trial and failure or intolerance to generic epinephrine</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>AUVI-Q EPIPEN 2-PAK EPIPEN JR 2-PAK</p>
Mental Health - Depression	<p>History of any TWO of the following: bupropion, citalopram, desvenlafaxine succinate ER, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, paroxetine ER, sertraline, venlafaxine, OR venlafaxine ER.</p>	<p>desvenlafaxine er KHEDEZLA PAXIL TRINTELLIX</p>
Mental Health - Mood Stabilizers	<p>History of ONE of the following: aripiprazole, olanzapine, quetiapine, risperidone, asenapine OR SAPHRIS</p>	<p>CAPLYTA FANAPT VRAYLAR</p>
Stomach Medications - IBS Constipation	<p>Requires any ONE of the following generics: lactulose, polyethylene glycol AND any ONE of the following preferred brands: Linzess, Movantik, or Symproic</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>AMITIZA lubiprostone</p>
	<p>History of ONE of the following: lactulose OR polyethylene glycol (PEG)</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>LINZESS</p>

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
Stomach Medications - IBS Constipation	History of ONE of the following: lactulose OR polyethylene glycol (PEG) AND LINZESS. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	MOTEGRITY TRULANCE
	History of ONE of the following generics: lactulose, polyethylene glycol Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	MOVANTIK SYMPROIC
	Requires any ONE of the following generics: lactulose, polyethylene glycol AND any ONE of the following preferred brands: Movantik or Symproic Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	RELISTOR
Stomach Medications - IBS/IBD	History of the following: APRISO ER. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	ASACOL HD DELZICOL LIALDA
Stomach Medications - Pancreatic Enzymes	History of BOTH of the following: CREON AND ZENPEP. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	PANCREAZE PERTZYE VIOKACE
Topical - Acne Combinations	History of ONE of the following: EPIDUO FORTE OR ONEXTON Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	ACANYA AKTIPAK BENZAACLIN BENZAMYCIN DUAC VELTIN ZIANA
Topical - Atopic Dermatitis	History of one prescription strength topical corticosteroid.	EUCRISA
Topical - Cancer Medications	History of one of the following topical generics: fluorouracil or imiquimod.	diclofenac sodium PICATO SOLARAZE

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
<p>Topical Rosacea</p>	<p>Any one of the following generic or brand products: azelaic acid gel, SOOLANTRA, or FINACEA FOAM.</p> <p>Note: Please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>FINACEA NORITATE ZILXI</p>
	<p>Any one of the following generic or brand products: metronidazole gel, SOOLANTRA, or FINACEA FOAM.</p> <p>Note: Please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>METROGEL</p>

DISCRIMINATION IS AGAINST THE LAW

Final Rule Under Section 1557 for Nondiscrimination and Accessibility Requirements

We comply with applicable Federal civil rights laws and the Minnesota Human Rights Act. We do not discriminate against, exclude, or treat people differently or deny any person the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of a place of public accommodation because of race, color, creed, religion, national origin, marital status, age, disability, sexual orientation or sex.

We provide free aids and services to help people communicate effectively with us, such as:

- Qualified sign language interpreters, call 612-273-3780.
- TTY for hearing and language impaired, dial 711.
- Qualified spoken language interpreters, for people whose preferred language is not English, call 1-844-278-9798
- Written information in other languages and formats (such as large print, audio and accessible electronic formats), call 612-273-3780.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, creed, religion, national origin, marital status, age, disability, sexual orientation or sex, you can file a grievance with your facility in person or by mail, fax or email. The contacts listed below will help you. For a copy of our grievance procedure, go to: <http://www.fvfiles.com/524620.pdf>.

ClearScriptSM

Fairview Pharmacy Services

Corporate Office, 711 Kasota Ave. S.E., Minneapolis, MN 55414

Phone: 612-617-3513

Fax: 612-672-5201

Email: dept-pharm-compliance@fairview.org

You can also file a non-discrimination complaint with the U.S. Department of Health and Human Services and/or Minnesota Department of Human Rights:

U.S. Department of Health and Human Services, Office for Civil Rights:

- Electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.
- By mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201.
- By phone: 1-800-368-1019, 800-537-7697 (TDD).
- Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>.

Minnesota Department of Human Rights:

- Electronically through the MDHR complaint inquiry form, available at <https://b5.caspio.com/dp.asp?AppKey=18a340001049f4ae67b24974b4ec>.
- By mail at: Minnesota Department of Human Rights, 625 Robert Street North, Saint Paul, MN 55155.
- By phone: 651.539.1100 (TTY 651.296.1283) or Toll Free at 800.657.3704.

LANGUAGE SERVICES

1-844-278-9798 (TTY: 711) – Available 24 Hours

ATTENTION: Language assistance services, free of charge, are available to you.
Call 1-844-278-9798.



Somali

FIIRO GAAR AH: Hadii aad ku hadasho Soomaali, waaxda luqadaha, qaybta kaalmada adeegyada, waxay idiin hayaan adeeg kharash la'aan ah.
So wac 1-844-278-9798.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-844-278-9798.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-278-9798.

Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-278-9798.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-278-9798.

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-278-9798.

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-278-9798.

Chinese

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-844-278-9798。

Amharic

ግልጽ: የግንባታ ቋንቋ አገልግሎት ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-844-278-9798.

Cambodian

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-844-278-9798 ។

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-278-9798.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-278-9798 번으로 전화해 주십시오.

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-278-9798.

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-278-9798 تماس بگیرید.

Karen

ဟံသုၣ်ဟံသး- နမ့ၢ်ကတိၤ ကညီၣ် ကျိၣ်အယံၤ, နမ့ၢ်န့ၢ် ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢၣ်ဘျုးလၢၣ်စ့ၤ နိတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိ: 1-844-278-9798

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-278-9798.

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-278-9798.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-278-9798.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-278-9798.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-278-9798.

Japanese

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-844-278-9798 まで、お電話にてご連絡ください。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-844-278-9798.