

## 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
<b>Asthma/COPD - Long-Acting Combo Inhalers</b>	<p>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.</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	DULERA

**Step Therapy Medications**

Condition / Drug Class	First Step Drugs	Second Step Drugs
<p><b>Attention Disorder - Stimulants</b></p>	<p>History of TWO of the following: amphetamine-dextroamphetamine, dexamethylphenidate, dextroamphetamine, methylphenidate, OR VYVANSE.</p>	<p>ADDERALL ADDERALL XR ADZENYS ER amphetamine amphetamine sulfate APTENSIO XR CONCERTA DAYTRANA DESOXYN DYANAVEL XR EVEKEO EVEKEO ODT FOCALIN FOCALIN XR KAPVAY METADATE CD methamphetamine hcl METHYLIN methylphenidate er MYDAYIS procentra QUILLICHEW ER QUILLIVANT XR RITALIN RITALIN LA ZENZEDI zenzedi</p>
	<p>History of ONE of the following: amphetamine-dextroamphetamine, dexamethylphenidate, dextroamphetamine, methylphenidate, OR VYVANSE.</p>	<p>ADZENYS XR-ODT COTEMPLA XR-ODT</p>
<p><b>CUSTOM UM - ANTIPSYCHOTICS - ATYPICALS</b></p>	<p>History of ONE of the following: aripiprazole, olanzapine, quetiapine, risperidone, asenapine OR SAPHRIS</p>	<p>CAPLYTA FANAPT VRAYLAR</p>
<p><b>Diabetic Medications</b></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>

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<b>Gout Medications</b>	<p>Trial and failure, contraindication, or intolerance to Colcris</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>colchicine GLOPERBA MITIGARE</p>
<b>Mental Health - Depression</b>	<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>BRINTELLIX KHEDEZLA PAXIL TRINTELLIX</p>
<b>TARGETED UM - DIABETES - BLOOD GLUCOSE METERS</b>	<p>History of BOTH of the following preferred brands of blood glucose meters: ACCU-CHEK AND ONE TOUCH.</p> <p>Note: 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>
<b>TARGETED UM - DIABETES - BLOOD GLUCOSE TEST STRIPS</b>	<p>History of BOTH of the following preferred brands of blood glucose test strips: ACCU-CHEK AND ONE TOUCH.</p> <p>Note: 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>
<b>TARGETED UM - DIABETES - DPP-4 A</b>	<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>
<b>TARGETED UM - DIABETES - DPP-4 B</b>	<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 KAZANO KOMBIGLYZE XR NESINA ONGLYZA</p>

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<b>TARGETED UM - DIABETES - GLP-1 A</b>	<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>
<b>TARGETED UM - DIABETES - GLP-1 B</b>	<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>
<b>TARGETED UM - DIABETES - INSULIN GLARGINE</b>	<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>
<b>TARGETED UM - DIABETES - SGLT2 A</b>	<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>
<b>TARGETED UM - DIABETES - SGLT2 B</b>	<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>

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<b>TARGETED UM - DIABETES - SHORT ACTING INSULIN</b>	<p>History of BOTH of the following: HUMALOG (insulin lispro) AND NOVOLOG (insulin aspart).</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</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 LYUMJEV LYUMJEV KWIKPEN U-100 LYUMJEV KWIKPEN U-200
<b>TARGETED UM - EPINEPHRINE AUTO-INJECTORS</b>	<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>	EPIPEN 2-PAK EPIPEN JR 2-PAK
<b>TARGETED UM - GASTROINTESTINAL - PANCREATIC ENZYMES</b>	<p>History of BOTH of the following: CREON AND ZENPEP.</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	PANCREAZE PERTZYE VIOKACE
<b>TARGETED UM - IBS CONSTIPATION A</b>	<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>	LINZESS

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<b>TARGETED UM - IBS CONSTIPATION B</b>	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
<b>TARGETED UM - IBS CONSTIPATION C</b>	Requires any ONE of the following generics: lactulose, polyethylene glycol AND any ONE of the following preferred brands: Linzess, Movantik, or Symproic  Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	AMITIZA
<b>TARGETED UM - IBS/IBD - AMINOSALICYLATES</b>	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
<b>TARGETED UM - OPIOID INDUCED CONSTIPATION A</b>	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
<b>TARGETED UM - OPIOID INDUCED CONSTIPATION B</b>	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
<b>TARGETED UM - RESPIRATORY - INHALED CORTICOSTEROIDS</b>	History of TWO of the following: ARNUITY ELLIPTA, FLOVENT DISKUS/HFA, PULMICORT FLEXHALER, QVAR, OR QVAR REDIHALER  Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	ALVESCO ARMONAIR RESPICLICK ASMANEX ASMANEX HFA
<b>TARGETED UM - RESPIRATORY - LONG- ACTING BRONCHODILATOR COMBINATIONS A</b>	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 RESPICLICK

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<b>TARGETED UM - RESPIRATORY - LONG- ACTING BRONCHODILATORS B</b>	History of BOTH of the following: INCRUSE ELLIPTA AND SPIRIVA.  Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	SEEBRI NEOHALER TUDORZA PRESSAIR
<b>TARGETED UM - RESPIRATORY - SHORT- ACTING BRONCHODILATORS</b>	History of VENTOLIN HFA AND ONE of the following preferred brands: PROAIR HFA OR PROAIR RESPICLICK.  Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	albuterol sulfate hfa levalbuterol tartrate hfa PROAIR DIGIHALER PROVENTIL HFA XOPENEX HFA
<b>TARGETED UM - RESPIRATORY - TOBRAMYCIN INHALED PRODUCTS</b>	History of Bethkis.  Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	KITABIS PAK TOBI tobramycin
<b>TARGETED UM - TOPICAL - ACNE</b>	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.	AKTIPAK BENZACLIN BENZAMYCIN DUAC
<b>TARGETED UM - TOPICAL - ROSACEA A</b>	Any one of the following preferred generics or brands: ivermectin cream or Soolantra.  Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	FINACEA
<b>Topical - Atopic Dermatitis</b>	History of one prescription strength topical corticosteroid.	EUCRISA
<b>Topical - Cancer Medications</b>	History of one of the following topical generics: fluorouracil or imiquimod.	diclofenac sodium PICATO

## PreferredOne Insurance Company Nondiscrimination Notice

PreferredOne Insurance Company (“PIC”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PIC:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist  
PreferredOne Insurance Company  
PO Box 59212  
Minneapolis, MN 55459-0212  
Phone: 1.800.940.5049 (TTY: 763.847.4013)  
Fax: 763.847.4010  
Email: [customerservice@preferredone.com](mailto:customerservice@preferredone.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the 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>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Y: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

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ໂປດຊາບ: ຖ້າວ່າທ່ານບໍ່ເຂົ້າໃຈພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອອັດຕະໂນມາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຄວນມາພົວພັນກັບພວກເຮົາ. ໂທ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች: በነጻ ሊያግዝዎት ተዘጋጅተዋል: ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው: 763.847.4013) .

တံသိုလ်သ်း- နမူကတိံ ကညိံ ကိုဝ်ဆယိံ, နမူန့ ကိုဝ်ဆတိံမတေလါ တလၢ်ဘူၣ်လၢ်စ့ၢ် နိတမံဘၣ်သ့န့ၣ်လိၤ. ကိံ: 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013) ។

ملحوظة: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).



## PreferredOne Community Health Plan Nondiscrimination Notice

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Grievance Specialist  
PreferredOne Community Health Plan  
PO Box 59052  
Minneapolis, MN 55459-0052  
Phone: 1.800.940.5049 (TTY: 763.847.4013)  
Fax: 763.847.4010  
[customerservice@preferredone.com](mailto:customerservice@preferredone.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the 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>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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ໂປດຊາວ: ຖ້າວ່າທ່ານບໍ່ເຂົ້າໃຈພາສາອັງກฤษ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈະມີສຳລັບທ່ານ. ໂທສ

1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች: በነጻ ሊያገኙት ተዘጋጅተዋል: ወደ ሚክተለው ቁጥር ይደውሉ 1.800.940.5049

(ማስማት ለተሳናቸው: 763.847.4013) .

တံသ့ၣ်တံသး- နမူကတိၣ် ကညီ ကိုၣ်အထိ, နမူနာ ကိုၣ်အတိၣ်မစၢလၢ တလၢဘၣ်သ့ၣ်လၢဘၣ်စၢ နီတံၣ်ဘၣ်သ့ၣ်န့ၣ်လီၤ. ကိ: 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013) ។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).