

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
<p>Asthma/COPD - Steroid Inhalers</p>	<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>	<p>ALVESCO ARMONAIR DIGIHALER ARMONAIR RESPICLICK ASMANEX ASMANEX HFA</p>
<p>Attention Disorder - Stimulants</p>	<p>History of TWO of the following: amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, methylphenidate, OR VYVANSE.</p>	<p>ADDERALL ADDERALL XR ADHANSIA XR ADZENYS ER amphetamine amphetamine sulfate APTENSIO XR AZSTARYS CONCERTA DAYTRANA DESOXYN dextroamphetamine sulfate 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 zenzedi</p>
	<p>History of ONE of the following: amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, methylphenidate, OR VYVANSE.</p>	<p>ADZENYS XR-ODT COTEMPLA XR-ODT</p>

Step Therapy Medications

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Custom UM - Diabetes - Short Acting Insulin	History of TWO of the following: HUMALOG (insulin lispro), NOVOLOG (insulin aspart), or LYUMJEV (insulin lispro).	ADMELOG ADMELOG SOLOSTAR APIDRA APIDRA SOLOSTAR FIASP FIASP FLEXTOUCH FIASP PENFILL
Diabetes - Blood Glucose Meters	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, CONTOUR NEXT GLUCOSE METER KIT. Note: Exceptions may apply. Please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	All non-preferred brands and generics of blood glucose meters.
Diabetes - Blood Glucose Test Strips	History of the following preferred brand of blood glucose test strips: CONTOUR. Note: Exceptions may apply. Please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	All non-preferred brands and generics of blood glucose test strips.
Diabetic Medications	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 Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	ADLYXIN
	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. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	alogliptin alogliptin-metformin alogliptin-pioglitazone KAZANO KOMBIGLYZE XR NESINA ONGLYZA OSENI

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Diabetic Medications	<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 INSULIN GLARGINE-YFGN SEMGLEE SEMGLEE (YFGN) SEMGLEE (YFGN) PEN 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>

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Diabetic Medications	<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>INSULIN ASPART INSULIN ASPART FLEXPEN INSULIN ASPART PENFILL INSULIN ASPART PROT MIX 70-30 INSULIN LISPRO INSULIN LISPRO JUNIOR KWIKPEN INSULIN LISPRO KWIKPEN U-100 INSULIN LISPRO PROTAMINE MIX NOVOLOG NOVOLOG FLEXPEN NOVOLOG MIX 70-30 NOVOLOG MIX 70-30 FLEXPEN</p>
	<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 paroxetine hcl PAXIL TRINTELLIX</p>

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Mental Health - Mood Stabilizers	History of ONE of the following: aripiprazole, olanzapine, quetiapine, risperidone, asenapine OR SAPHRIS	CAPLYTA FANAPT VRAYLAR
Stomach Medications - IBS Constipation	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 lubiprostone
	History of ONE of the following: lactulose OR polyethylene glycol (PEG) Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	LINZESS
	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

Step Therapy Medications

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Stomach Medications - Pancreatic Enzymes	<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>	<p>PANCREAZE PERTZYE VIOKACE</p>
Topical - Acne Combinations	<p>History of ONE of the following: EPIDUO FORTE OR ONEXTON</p> <p>Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.</p>	<p>ACANYA BENZACLIN BENZAMYCIN VELTIN ZIANA</p>
Topical - Atopic Dermatitis	<p>History of one prescription strength topical corticosteroid.</p>	<p>EUCRISA</p>
Topical - Cancer Medications	<p>History of one of the following topical generics: fluorouracil or imiquimod.</p>	<p>diclofenac sodium PICATO SOLARAZE</p>
Topical Rosacea	<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>

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:

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- 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

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).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

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, ຄວນມາພົວພັນໃຫ້ທ່ານ. 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) .

တံသိုလ်သး- နမူကတိ ကညီ ကိုဝိဆယ်, နမူနို ကိုဝိဆတ်မစၢလၢ တလၢဝ်သိုလ်သးစ့၊ နိုတမံဘၣ်သုန့ၣ်လိၤ. 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 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).

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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

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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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1.800.940.5049 (TTY: 763.847.4013).

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(ማስማት ለተሳናቸው: 763.847.4013) .

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

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