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 - Steroid Inhalers	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 DIGIHALER ARMONAIR RESPICLICK ASMANEX ASMANEX HFA

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
Attention Disorder - Stimulants	History of TWO of the following: amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, methylphenidate, OR VYVANSE.	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 METADATE CD methamphetamine hcl METHYLIN methylphenidate er MYDAYIS procentra QUILLICHEW ER QUILLIVANT XR RITALIN RITALIN LA ZENZEDI zenzedi
	History of ONE of the following: amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, methylphenidate, OR VYVANSE.	ADZENYS XR-ODT COTEMPLA XR-ODT
CUSTOM UM - ANTIPSYCHOTICS - ATYPICALS	History of ONE of the following: aripiprazole, olanzapine, quetiapine, risperidone, asenapine OR SAPHRIS	CAPLYTA FANAPT VRAYLAR
Cystic Fibrosis - Inhaled Tobramycin	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

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
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 BOTH of the following: HUMALOG (insulin lispro) AND NOVOLOG (insulin aspart). Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	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
	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

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
Diabetic Medications	History of TWO of the following: LANTUS, LEVEMIR, TRESIBA AND TOUJEO. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	BASAGLAR KWIKPEN U-100 SEMGLEE SEMGLEE PEN
	Any one of the following generics: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	BYDUREON BYDUREON BCISE BYDUREON PEN BYETTA OZEMPIC RYBELSUS TRULICITY VICTOZA 2-PAK VICTOZA 3-PAK
	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 Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	FARXIGA
	History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, OR pioglitazone-metformin Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	GLYXAMBI JARDIANCE SYNJARDY SYNJARDY XR TRIJARDY XR XIGDUO XR
	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. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	INVOKAMET INVOKAMET XR INVOKANA QTERN SEGLUROMET STEGLATRO STEGLUJAN

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Condition / Drug Class	First Step Drugs	Second Step Drugs
Diabetic Medications	History of ONE of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, OR pioglitazone-metformin. Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	JANUMET JANUMET XR JANUVIA JENTADUETO JENTADUETO XR TRADJENTA
Epinephrine Auto-Injectors	Trial and failure or intolerance to generic epinephrine Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	AUVI-Q EPIPEN 2-PAK EPIPEN JR 2-PAK
Gout Medications	Trial and failure, contraindication, or intolerance to Colcrys Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	colchicine GLOPERBA MITIGARE
Mental Health - Depression	History of any TWO of the following: bupropion, citalopram, desvenlafaxine succinate ER, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, paroxetine ER, sertraline, venlafaxine, OR venlafaxine ER.	BRINTELLIX desvenlafaxine er KHEDEZLA PAXIL TRINTELLIX
Pain Management - Non-Narcotic	History of any TWO of the following: diclofenac, diflunisal, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meclofenamate, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, sulindac, OR tolmetin Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	CAMBIA
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
	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

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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
TARGETED UM - DIABETES - BLOOD GLUCOSE METERS	History of BOTH of the following preferred brands of blood glucose meters: ACCU-CHEK AND ONE TOUCH. Note: 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.
TARGETED UM - DIABETES - BLOOD GLUCOSE TEST STRIPS	History of BOTH of the following preferred brands of blood glucose test strips: ACCU-CHEK AND ONE TOUCH. Note: 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.

Step Therapy Medications

Condition / Drug Class	First Step Drugs	Second Step Drugs
TARGETED UM - RESPIRATORY - LONG-ACTING BRONCHODILATORS 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
TARGETED UM - RESPIRATORY - SHORT-ACTING BRONCHODILATORS	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
TARGETED UM - TOPICAL - ROSACEA A	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
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 BENZACLIN 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
Topical Rosacea	History of one of the following preferred brands: SOOLANTRA Note: please refer to the formulary plan for drug coverage and medication tier placement. Drug exclusions may apply.	ZILXI

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

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).

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

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ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው: 763.847.4013).

ဟသ္ဥပဟ်သး– နမ့်ကတိၤ, ကညီ ကျိာ်အယိ, နမၤန့ဲ ကျိာ်အတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စုၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

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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).

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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

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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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).