

2024 CONNECTED ACCESS Step Therapy Criteria

Aggrenox - B

Products Affected

- *aspirin-dipyridamole er capsule extended release 12 hour 25-200 mg oral*

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): clopidogrel. Step 2 Drug(s): aspirin/extended-release dipyridamole. Applies to New Starts Only.
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

Aptiom - D

Products Affected

- APTIOM TABLET 200 MG ORAL
- APTIOM TABLET 400 MG ORAL
- APTIOM TABLET 600 MG ORAL
- APTIOM TABLET 800 MG ORAL

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): Lamotrigine IR, Levetiracetam IR\XR, Oxcarbazepine IR, Topiramate IR, Zonisamide. Step 2 Drug(s): Aptiom (eslicarbazepine). Applies to New Starts Only.
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

Cycloset

Products Affected

- CYCLOSET TABLET 0.8 MG ORAL

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): metformin. Step 2 Drug(s): Cycloset (bromocriptine mesylate)
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

Dexilant - B

Products Affected

- *dexlansoprazole capsule delayed release 30 mg oral*
- *dexlansoprazole capsule delayed release 60 mg oral*

Details

Criteria	If the patient has tried ONE Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): omeprazole, pantoprazole, or lansoprazole. Step 2 Drug(s): Dexlansoprazole. New Starts
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

MTX

Products Affected

- TREXALL TABLET 10 MG ORAL
- TREXALL TABLET 15 MG ORAL
- XATMEP SOLUTION 2.5 MG/ML ORAL

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): methotrexate sodium. Step 2 Drug(s): Trexall (methotrexate), Xatmep (methotrexate).
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

NP Bisphosphonates - B

Products Affected

- FOSAMAX PLUS D TABLET 70-2800 MG-UNIT ORAL
- FOSAMAX PLUS D TABLET 70-5600 MG-UNIT ORAL
- *risedronate sodium tablet 150 mg oral*
- *risedronate sodium tablet 30 mg oral*
- *risedronate sodium tablet 35 mg oral*
- *risedronate sodium tablet 5 mg oral*
- *risedronate sodium tablet delayed release 35 mg oral*

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): Alendronate, ibandronate tablets. Step 2 Drug(s): Risedronate, Fosamax plus D.
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

NP Fast Acting Insulin - B

Products Affected

- NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS
SUSPENSION PEN-INJECTOR (70-30)
100 UNIT/ML SUBCUTANEOUS
- NOVOLIN 70/30 FLEXPEN
SUSPENSION PEN-INJECTOR (70-30)
100 UNIT/ML SUBCUTANEOUS
- NOVOLIN 70/30 RELION SUSPENSION
(70-30) 100 UNIT/ML SUBCUTANEOUS
- NOVOLIN 70/30 SUSPENSION (70-30)
100 UNIT/ML SUBCUTANEOUS
- NOVOLIN N FLEXPEN RELION
SUSPENSION PEN-INJECTOR 100
UNIT/ML SUBCUTANEOUS
- NOVOLIN N FLEXPEN SUSPENSION
PEN-INJECTOR 100 UNIT/ML
- NOVOLIN N RELION SUSPENSION
100 UNIT/ML SUBCUTANEOUS
- NOVOLIN N SUSPENSION 100
UNIT/ML SUBCUTANEOUS
- NOVOLIN R FLEXPEN RELION
SOLUTION PEN-INJECTOR 100
UNIT/ML INJECTION
- NOVOLIN R FLEXPEN SOLUTION
PEN-INJECTOR 100 UNIT/ML
INJECTION
- NOVOLIN R RELION SOLUTION 100
UNIT/ML INJECTION
- NOVOLIN R SOLUTION 100 UNIT/ML
INJECTION

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): Humulin N, R, 70/30 (pen/vial). Step 2 Drug(s): Novolin N, R, 70/30 (pen/vial). New starts Only.
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NP OAB - L

Products Affected

- GELNIQUE GEL 10 % TRANSDERMAL

Details

Criteria	If the patient has tried Gemtesa/Myrbetriq and one of the following: darifenacin ER, oxybutynin, oxybutynin sol/syr, oxybutynin ER, tolterodine IR/ER, solifenacin, OR trospium IR/ER. Then Gelnique (oxybutynin), will be covered.
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

NP RAPID INSULIN

Products Affected

- APIDRA SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS
- APIDRA SOLUTION 100 UNIT/ML INJECTION
- *insulin asp prot & asp flexpen suspension pen-injector (70-30) 100 unit/ml subcutaneous*
- *insulin aspart flexpen solution pen-injector 100 unit/ml subcutaneous*
- *insulin aspart penfill solution cartridge 100 unit/ml subcutaneous*
- *insulin aspart prot & aspart suspension (70-30) 100 unit/ml subcutaneous*
- *insulin aspart solution 100 unit/ml injection*
- NOVOLOG 70/30 FLEXPEN RELION SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS
- NOVOLOG FLEXPEN RELION SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS
- NOVOLOG FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS
- NOVOLOG MIX 70/30 FLEXPEN SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS
- NOVOLOG MIX 70/30 RELION SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS
- NOVOLOG MIX 70/30 SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS
- NOVOLOG PENFILL SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS
- NOVOLOG RELION SOLUTION 100 UNIT/ML INJECTION
- NOVOLOG SOLUTION 100 UNIT/ML INJECTION

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): Humalog, Insulin Lispro, Humalog Mix, Insulin Lispro/insulin lispro protamine, Lyumjev (insulin lispro-aabc). Step 2 Drug(s): Apidra (Insulin Glulisine), Novolog, Insulin Aspart, Novolog Mix, Insulin Aspart/insulin aspart protamine. New starts Only.
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PERT Agents - D

Products Affected

- PANCREAZE CAPSULE DELAYED
RELEASE PARTICLES 10500-35500
UNIT ORAL
- PANCREAZE CAPSULE DELAYED
RELEASE PARTICLES 16800-56800
UNIT ORAL
- PANCREAZE CAPSULE DELAYED
RELEASE PARTICLES 21000-54700
UNIT ORAL
- PANCREAZE CAPSULE DELAYED
RELEASE PARTICLES 2600-8800 UNIT
ORAL
- PANCREAZE CAPSULE DELAYED
RELEASE PARTICLES 37000-97300
UNIT ORAL
- PANCREAZE CAPSULE DELAYED
RELEASE PARTICLES 4200-14200
UNIT ORAL
- PERTZYE CAPSULE DELAYED
RELEASE PARTICLES 16000-57500
UNIT ORAL
- PERTZYE CAPSULE DELAYED
RELEASE PARTICLES 24000-86250
UNIT ORAL
- PERTZYE CAPSULE DELAYED
RELEASE PARTICLES 4000-14375
UNIT ORAL
- PERTZYE CAPSULE DELAYED
RELEASE PARTICLES 8000-28750
UNIT ORAL

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): Creon or Zenpep. Step 2 Drug(s): Pancreaze, Pertzye. New Starts Only
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

Rytary

Products Affected

- RYTARY CAPSULE EXTENDED RELEASE 23.75-95 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 36.25-145 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 48.75-195 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 61.25-245 MG ORAL

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): carbidopa, carbidopa/levodopa IR/ER. Step 2 Drug(s): Rytary (carbidopa/levodopa).
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

ULORIC - B

Products Affected

- *febuxostat tablet 40 mg oral*
- *febuxostat tablet 80 mg oral*

Details

Criteria	If the patient has tried a Step 1 drug, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): allopurinol. Step 2 Drug(s): Febuxostat. Approve without trial of step 1 drug if Patient has contraindication to allopurinol use.
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

Viibryd - C

Products Affected

- *vilazodone hcl tablet 10 mg oral*
- *vilazodone hcl tablet 20 mg oral*
- *vilazodone hcl tablet 40 mg oral*

Details

Criteria	If the patient has tried TWO Step 1 drugs, then authorization for a Step 2 drug will be covered. Step 1 Drug(s): citalopram, desvenlafaxine ER, escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine ER, sertraline, venlafaxine IR/ER. Step 2 Drug(s): Vilazodone. Applies to New Starts Only.
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H1350_PBM24152_C
H9656_PBM24336_C

EFFECTIVE DATE 12/01/2024

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-627-1188 (TTY: 711). Someone who speaks English can help you. This is a free service.

Form Approved
OMB# 0938-1421

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-627-1188 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 1-800-627-1188 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 請此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-800-627-1188 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-800-627-1188 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-627-1188 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-627-1188 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-627-1188 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-627-1188 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-627-1188 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري, ليس عليك سوى الاتصال بنا على 1-800-627-1188 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-627-1188 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-627-1188 (TTY: 711). Un nostro incaricato che parla Italiano fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-627-1188 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-627-1188 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatnie skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-627-1188 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬 ランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳 ご用意になるには、1-800-627-1188 (TTY: 711) にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Farsi: دی نک یم وگتفگ یسراف نابز هب رگا: هجوت، یم مهارف امش یارب ناگیار تروصب ی نابز تالیست یدی رگب سامت 1-800-627-1188 (TTY: 711) اب دشاب.

Nepali: ध्यान दनुहोस्: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नमिती भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टिडिडिडि: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY: Telefon za osobe sa oštećenim govorom ili sluhom: 711).