

## Step Therapy Medications

### Tiered Drug List – Open Formulary & Custom Premium Drug List – Closed Formulary

Step therapy is a limitation that requires you to try preferred medications before the plan will pay for another medication for the same medical condition that the doctor may have originally prescribed. An automated, electronic review of your medication history is performed to determine whether other medications have been tried first for your condition. This ensures clinically sound and cost-effective treatment options are tried. If a prescribed medication does not meet the step therapy criteria, it may not be covered. You should consult with your doctor about alternative therapy. If a medication does not meet the step therapy criteria for automatic approval, it will reject at the pharmacy; your provider may request prior authorization.

### Questions?

Log in to MyBlue<sup>SM</sup> to find participating retail pharmacies, review your specific benefit information, and compare medication pricing and options. If you have questions, please call us.

Member Services	Phone Number	Standard Hours of Operation
Pharmacy Benefits	1 (866) 325-1794	24/7/365
AZ Blue	Call the number on your ID card	8 a.m. to 5 p.m. Monday - Friday

# Step Therapy Drug List

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Step 2 Product	Step 1 Product
<b>*Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexiant*</b>	
<b>*Adhd Agent - Selective Norepinephrine Reuptake Inhibitor***</b>	
<b>QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG</b>	QL (1 capsule per day); ST (Step Therapy required: 3 months in the last 12 months - atomoxetine (generic for Strattera))
<b>QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG</b>	QL (3 capsules per day); ST (Step Therapy required: 3 months in the last 12 months - atomoxetine (generic for Strattera))
<b>*Amphetamine Mixtures***</b>	
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg</i>	QL (1 capsule per day); ST (Step Therapy required: any of the following for 3 months in the last 12 months - amphetamine/dextroamphetamine ER (generic Adderall XR) or Adderall XR); AL (Min 13 Years)
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 37.5 mg</i>	QL (1 capsule per day); ST ( Step Therapy required: any of the following for 3 months in the last 12 months - amphetamine/dextroamphetamine ER (generic Adderall XR) or Adderall XR); AL (Min 18 Years)
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 50 mg</i>	QL (1 capsule per day); ST (Step Therapy required: any of the following for 3 months in the last 12 months - amphetamine/dextroamphetamine ER (generic Adderall XR) or Adderall XR); AL (Min 18 Years)
<b>*Analgesics - Opioid*</b>	
<b>*Opioid Agonists***</b>	
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour</i>	QL (2 tablets per day); ST (Step Therapy required: 1 fill in the last 3 months - non-ER Tramadol tabs); AL (Min 16 Years)
<b>*Antiasthmatic And Bronchodilator Agents*</b>	
<b>*5-Lipoxygenase Inhibitors***</b>	
<i>zileuton er</i>	QL (2 tablets per day); ST (Step Therapy required: BOTH of the following for 3 months each in the last 12 months - montelukast AND zafirlukast); AL (Min 12 Years)
<b>ZYFLO</b>	QL (4 tablets per day); ST (Step Therapy required: BOTH of the following for 3 months each in the last 12 months - montelukast AND zafirlukast); AL (Min 12 Years)

Step 2 Product	Step 1 Product
<b>*Adrenergic Combinations***</b>	
<b>AIRDUO DIGIHALER</b>	QL (1 inhaler per month); ST (Step Therapy required: 2 of the following for 3 months each in the last 12 months - Advair (Diskus or HFA), Breo Ellipta, Wixela, fluticasone propionate/salmaterol, or brand Symbicort); AL (Min 12 Years)
<b>AIRDUO RESPICLICK 113/14</b>	QL (1 inhaler per month); ST (Step Therapy required: 2 of the following for 3 months each in the last 12 months - Advair (Diskus or HFA), Breo Ellipta, Wixela, fluticasone propionate/salmaterol, or brand Symbicort); AL (Min 12 Years)
<b>AIRDUO RESPICLICK 232/14</b>	QL (1 inhaler per month); ST (Step Therapy required: 2 of the following for 3 months each in the last 12 months - Advair (Diskus or HFA), Breo Ellipta, Wixela, fluticasone propionate/salmaterol, or brand Symbicort); AL (Min 12 Years)
<b>AIRDUO RESPICLICK 55/14</b>	QL (1 inhaler per month); ST (Step Therapy required: 2 of the following for 3 months each in the last 12 months - Advair (Diskus or HFA), Breo Ellipta, Wixela, fluticasone propionate/salmaterol, or brand Symbicort); AL (Min 12 Years)
<b>BEVESPI AEROSPHERE</b>	QL (1x 5.9gm or 1x 10.7gm inhaler per month); ST (Step Therapy required: Required trial of ALL of the following in the last 12 months: Anoro Ellipta, Stiolto Respimat, AND Spiriva (Handihaler or Respimat)); AL (Min 15 Years)
<b>BREYNA</b>	ST (Step Therapy required: 2 of the following for 3 months each in the last 12 months - Advair (Diskus or HFA), Breo Ellipta, Wixela, fluticasone propionate/salmaterol, or brand Symbicort)
<b>BREZTRI AEROSPHERE</b>	QL (1x 10.7gm inhaler per month); ST (Step Therapy required: ALL of the following for 3 months each in the last 12 months - Trelegy Ellipta, Bevespi Aerosphere, and Duaklir Pressair); AL (Min 18 Years)
<i>budesonide-formoterol fumarate</i>	ST (Step Therapy required: 2 of the following for 3 months each in the last 12 months - Advair (Diskus or HFA), Breo Ellipta, Wixela, fluticasone propionate/salmaterol, or brand Symbicort)
<b>DUAKLIR PRESSAIR</b>	QL (1 inhaler per month); ST (Step Therapy required: BOTH of the following in the last 6 months - Anoro Ellipta AND Symbicort); AL (Min 18 Years)

Step 2 Product	Step 1 Product
<b>DULERA</b>	QL (1x 8.8gm or 1x 13gm inhaler per month); ST (Step Therapy required: 2 of the following for 3 months each in the last 12 months - Advair (Diskus or HFA), Breo Ellipta, Wixela, fluticasone propionate/salmeterol, or brand Symbicort)
<i>umeclidinium-vilanterol</i>	ST (Step Therapy required: 1 fill in the last 12 months - anoro ellipta brand)
<b>*Beta Adrenergics***</b>	
<b>STRIVERDI RESPIMAT</b>	QL (4 inhalers per month); ST (Step Therapy required: Required trial of ALL of the following in the last 12 months: Anoro Ellipta, Stiolto Respimat, AND Spiriva (Handihaler or Respimat)); AL (Min 18 Years)
<b>*Bronchodilators - Anticholinergics***</b>	
<b>INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT</b>	ST (Step Therapy required: trial of Spiriva Handihaler or Spiriva Respimat in the last 12 months)
<b>*Steroid Inhalants***</b>	
<b>ARMONAIR DIGIHALER</b>	QL (1 inhaler per month); ST (Step Therapy required: 1 fill in the last 3 months - Flovent); AL (Min 12 Years)
<b>*Anticonvulsants*</b>	
<b>*Anticonvulsants - Misc.***</b>	
<b>APTIOM ORAL TABLET 200 MG, 400 MG</b>	QL (1 tablet per day); ST (Step Therapy required: 3 of the following in the last 12 months - gabapentin, lamotrigine, levetiracetam, oxcarbazepine, pregabalin, topiramate, or zonisamide)
<b>APTIOM ORAL TABLET 600 MG, 800 MG</b>	QL (2 tablets per day); ST (Step Therapy required: 3 of the following in the last 12 months - gabapentin, lamotrigine, levetiracetam, oxcarbazepine, pregabalin, topiramate, or zonisamide)
<b>BRIVIACT ORAL SOLUTION</b>	QL (20ml per day); ST (Step Therapy required: 2 months in the last 12 months - levetiracetam tabs, levetiracetam 100mg/ml solution, or levetiracetam ER tabs (generic for Keppra)); AL (Min 4 Years)
<b>BRIVIACT ORAL TABLET</b>	QL (2 tablets per day); ST (Step Therapy required: 2 months in the last 12 months - levetiracetam tabs, levetiracetam 100mg/ml solution, or levetiracetam ER tabs (generic for Keppra)); AL (Min 4 Years)
<b>ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG</b>	QL (3 tablets per day); ST (Step Therapy required: 3 months in the last 12 months - levetiracetam 24hr tab (generic for Keppra XR)); AL (Min 12 Years)

Step 2 Product	Step 1 Product
<b>ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 1500 MG</b>	QL (2 tablets per day); ST (Step Therapy required: 3 months in the last 12 months - levetiracetam 24hr tab (generic for Keppra XR)); AL (Min 12 Years)
<b>EPRONTIA</b>	QL (16ml day or 473ml per 30 days); ST (Step Therapy required: BOTH of the following for 3 months in the last 12 months - topiramate (generic for Topamax) AND topiramate ER (generic for Qudexy XR))
<i>eslicarbazepine acetate oral tablet 200 mg, 400 mg</i>	QL (1 tablet per day); ST (Step Therapy required: 3 of the following in the last 12 months - gabapentin, lamotrigine, levetiracetam, oxcarbazepine, pregabalin, topiramate, or zonisamide)
<i>eslicarbazepine acetate oral tablet 600 mg, 800 mg</i>	QL (2 tablets per day); ST (Step Therapy required: 3 of the following in the last 12 months - gabapentin, lamotrigine, levetiracetam, oxcarbazepine, pregabalin, topiramate, or zonisamide)
<i>topiramate er oral capsule er 24 hour sprinkle</i>	QL (1 capsule per day); ST (Step Therapy required: 3 months in the last 12 months - topiramate (generic for Topamax)); AL (Min 3 Years)
<i>topiramate er oral capsule extended release 24 hour</i>	QL (1 capsule per day); ST (Step Therapy required: BOTH of the following for 3 months in the last 12 months - topiramate (generic for Topamax) AND topiramate ER (generic for Qudexy XR)); AL (Min 6 Years)
<b>*Carbamates***</b>	
<b>XCOPRI</b>	QL (1 tablet per day); ST (Step therapy required: Step Therapy required: 3 of the following in the last 12 months - carbamazepine, lacosamide (generic for Vimpat), lamotrigine, levetiracetam IR, oxcarbazepine, topiramate, or valproic acid & derivatives); AL (Min 18 Years)
<b>XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 &amp; 150 MG</b>	QL (2 tablets per day); ST (Step therapy required: Step Therapy required: 3 of the following in the last 12 months - carbamazepine, lacosamide (generic for Vimpat), lamotrigine, levetiracetam IR, oxcarbazepine, topiramate, or valproic acid & derivatives); AL (Min 18 Years)
<b>XCOPRI (350 MG DAILY DOSE)</b>	QL (2 tablets per day); ST (Step therapy required: Step Therapy required: 3 of the following in the last 12 months - carbamazepine, lacosamide (generic for Vimpat), lamotrigine, levetiracetam IR, oxcarbazepine, topiramate, or valproic acid & derivatives); AL (Min 18 Years)

Step 2 Product	Step 1 Product
<b>*Antidepressants*</b>	
<b>*Serotonin Modulators***</b>	
TRINTELLIX ORAL TABLET 10 MG	QL (2 tablets per day); ST (Step Therapy required: at least one drug in both classes for at least 60 days each in the last 12 months - one selective serotonin reuptake inhibitor (SSRI) AND one serotonin norepinephrine reuptake inhibitor (SNRI)); AL (Min 18 Years)
TRINTELLIX ORAL TABLET 20 MG, 5 MG	QL (1 tablet per day); ST (Step Therapy required: at least one drug in both classes for at least 60 days each in the last 12 months - one selective serotonin reuptake inhibitor (SSRI) AND one serotonin norepinephrine reuptake inhibitor (SNRI)); AL (Min 18 Years)
<b>*Serotonin-Norepinephrine Reuptake Inhibitors (Snris)***</b>	
DRIZALMA SPRINKLE	ST (Step Therapy required: Through Cymbalta (brand or generic) for 3 months within last 6 months. ); AL (Min 7 Years)
FETZIMA	QL (1 capsule per day); ST (Step Therapy required: at least one drug in both classes for at least 60 days each in the last 12 months - one selective serotonin reuptake inhibitor (SSRI) AND one serotonin norepinephrine reuptake inhibitor (SNRI))
FETZIMA TITRATION	QL (1 capsule per day); ST (Step Therapy required: at least one drug in both classes for at least 60 days each in the last 12 months - one selective serotonin reuptake inhibitor (SSRI) AND one serotonin norepinephrine reuptake inhibitor (SNRI))
<b>*Antidiabetics*</b>	
<b>*Diabetic Other***</b>	
ZEGALOGUE	QL (0.6ml/day with fill limit of 2 fills/month); DS (2 day supply max); ST (Step Therapy required: 1 month in the last 12 months - generic Glucagon (NDC 00548585000)); AL (Min 6 Years)
<b>*Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors***</b>	
<i>alogliptin benzoate</i>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta); AL (Min 18 Years)

Step 2 Product	Step 1 Product
<b>NESINA</b>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta); AL (Min 18 Years)
<b>ONGLYZA</b>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta); AL (Min 16 Years)
<i>saxagliptin hcl</i>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta); AL (Min 16 Years)
<b>*Dipeptidyl Peptidase-4 Inhibitor-Biguanide Combinations***</b>	
<i>alogliptin-metformin hcl</i>	ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<b>KAZANO</b>	ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<b>KOMBIGLYZE XR</b>	ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<i>saxagliptin-metformin er</i>	ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<i>sitagliptin base-metformin hcl oral tablet 50-1000 mg</i>	ST (Step Therapy required: through at least one of each type of drug in BOTH categories for 3 months each in the last 12 months: Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<b>ZITUVIMET</b>	ST (Step Therapy required: through at least one of each type of drug in BOTH categories for 3 months each in the last 12 months: Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)



Step 2 Product	Step 1 Product
ZITUVIMET XR	ST (Step Therapy required: through at least one of each type of drug in BOTH categories for 3 months each in the last 12 months: Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<b>*Dpp-4 Inhibitor-Thiazolidinedione Combinations***</b>	
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<b>OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG</b>	ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Janumet/XR or Januvia AND Jentadueto/XR or Tradjenta)
<b>*Human Insulin***</b>	
<b>APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR</b>	QL (2ml per day); ST ( )
<i>insulin aspart penfill</i>	QL (2ml per day)
<i>insulin lispro prot &amp; lispro</i>	QL (2 ml per day)
<b>NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE</b>	QL (2ml per day)
<b>SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR</b>	QL (2 ml per day)
<b>SEMGLEE SUBCUTANEOUS SOLUTION</b>	QL (2 ml per day); ST (Step Therapy required: 1 month in the last 12 months - Lantus)
<b>*Sglt2 Inhibitor - Dpp-4 Inhibitor Combinations***</b>	
<b>QTERN</b>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 18 Years)
<b>STEGLUJAN</b>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 18 Years)
<b>*Sodium-Glucose Co-Transporter 2 (Sglt2) Inhibitors***</b>	
<i>bexagliflozin</i>	DS (30 day supply max); ST (Step Therapy required: at least one of each type of drug in both categories for 3 months each in the last 12 months - Farxiga or Xigduo XR and Glyxambi, Jardiance, Synjardy, Synjardy XR, or Trijardy))

Step 2 Product	Step 1 Product
<b>BRENZAVVY</b>	DS (30 day supply max); ST (Step Therapy required: at least one of each type of drug in both categories for 3 months each in the last 12 months - Farxiga or Xigduo XR and Glyxambi, Jardiance, Synjardy, Synjardy XR, or Trijardy))
<i>dapagliflozin propanediol</i>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 10 Years)
<b>INVOKANA</b>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 18 Years)
<b>STEGLATRO</b>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy)
<b>*Sodium-Glucose Co-Transporter 2 Inhibitor-Biguanide Comb***</b>	
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg</i>	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 10 Years)
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 5-1000 mg</i>	QL (2 tablets per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 10 Years)
<b>INVOKAMET</b>	QL (2 tablets per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 18 Years)
<b>INVOKAMET XR</b>	QL (2 tablets per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 18 Years)

Step 2 Product	Step 1 Product
SEGLUROMET	QL (2 tablets per day); ST (Step Therapy required: at least one of each type of drug in BOTH categories for 3 months each in the last 12 months - Farxiga or Xigduo XR AND Glyxambi, Jardiance, Synjardy/XR, or Trijardy); AL (Min 18 Years)
<b>*Antidotes And Specific Antagonists*</b>	
<b>*Opioid Antagonists***</b>	
ZIMHI	QL (1ml per 30 days); ST (Step Therapy required: 1 fill in the last 3 months - generic naloxone prefilled syringe); AL (Min 12 Years)
<b>*Antiemetics*</b>	
<b>*Antiemetic Combinations***</b>	
AKYNZEO ORAL	QL (1 capsule on first day of treatment); ST (Step Therapy required: simultaneous use of BOTH of the following in the last 3 months - ondansetron AND aprepitant); AL (Min 18 Years)
<b>*Antifungals*</b>	
<b>*Antifungal - Glucan Synthesis Inhibitors (Triterpenoids)***</b>	
BREXAFEMME	QL (4 tablets per day, 1 fill per month); DS (30 day supply max); ST (Step Therapy required: 1 fill in the last 3 months - Fluconazole)
<b>*Tetrazoles***</b>	
VIVJOA	QL (1 fill in 1 year); DS (84 day supply min / 90 day supply max); ST (Step Therapy required: 1 fill in the last 10 days - Fluconazole)
<b>*Antihistamines*</b>	
<b>*Antihistamines - Ethanolamines***</b>	
<i>carbinoxamine maleate er</i>	QL (4ml per day); DS (30 day supply max); ST (Step Therapy required: 1 month in the last 2 months - carbinoxamine 4mg tab); AL (Min 2 Years)
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE	QL (4ml per day); DS (30 day supply max); ST (Step Therapy required: 1 month in the last 2 months - carbinoxamine 4mg tab); AL (Min 2 Years)
<b>*Antihyperlipidemics*</b>	
<b>*Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb***</b>	
NEXLIZET	QL (1 tablet per day); ST (Step Therapy required: BOTH of the following for 2 months each in the last 12 months - two statins AND ezetimibe (generic for ZETIA)); AL (Min 18 Years)

Step 2 Product	Step 1 Product
<b>*Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors***</b>	
NEXLETOL	QL (1 tablet per day); ST (Step Therapy required: BOTH of the following for 2 months each in the last 12 months - two statins AND ezetimibe (generic for ZETIA)); AL (Min 18 Years)
<b>*Hmg Coa Reductase Inhibitors***</b>	
<i>pitavastatin calcium</i>	QL (1 tablet per day); ST (Step Therapy required: 2 of the following in the last 12 months - atorvastatin, simvastatin, or rosuvastatin); AL (Min 8 Years)
ZYPITAMAG ORAL TABLET 2 MG, 4 MG	QL (1 tablet per day); ST (Step Therapy required: 2 of the following in the last 12 months - atorvastatin, simvastatin, or rosuvastatin); AL (Min 8 Years)
<b>*Antipsychotics/Antimanic Agents*</b>	
<b>*Antipsychotics - Misc.***</b>	
VRAYLAR ORAL CAPSULE	QL (1 capsule per day); ST (Step Therapy required: 2 of the following in the last 12 months - aripiprazole, quetiapine, risperidone, Saphris, or ziprasidone); AL (Min 18 Years)
VRAYLAR ORAL CAPSULE THERAPY PACK	QL (1 box per 7 days); ST (Step Therapy required: 2 of the following in the last 12 months - aripiprazole, quetiapine, risperidone, Saphris, or ziprasidone); AL (Min 18 Years)
<b>*Beta Blockers*</b>	
<b>*Beta Blockers Cardio-Selective***</b>	
KAPSPARGO SPRINKLE	QL (1 capsule per day); ST (Step Therapy required: any of the following for 3 months in the last 12 months - metoprolol succinate tab ER 24HR or Toprol XL tab ER 24HR); AL (Min 6 Years)
<b>*Calcium Channel Blockers*</b>	
<b>*Calcium Channel Blockers***</b>	
CONJUPRI	QL (1 tablet per day); ST (Step Therapy required: 1 fill in the last 3 months - levamlodipine maleate)
<b>*Cardiovascular Agents - Misc.*</b>	
<b>*Cardiovascular SglT2 Inhibitors**</b>	
INPEFA	QL (1 tablet per day); ST (Step Therapy required: at least one of each type of drug in both categories for 3 months each in the last 12 months - Farxiga or Xigduo XR and Glyxambi, Jardiance, Synjardy, Synjardy XR, or Trijardy); AL (Min 18 Years)

Step 2 Product	Step 1 Product
<b>*Neprilysin Inhib (Arni)-Angiotensin li Recept Antag Comb***</b>	
ENTRESTO ORAL CAPSULE SPRINKLE	QL (3 capsules per day); ST (Step Therapy required: any of the following in the last 6 months - metoprolol, bisoprolol, or carvedilol. ); AL (Max 6 Years)
ENTRESTO ORAL TABLET	QL (2 tablets per day); ST (Step Therapy required: any of the following in the last 6 months - metoprolol, bisoprolol, or carvedilol)
<b>*Pulmonary Hypertension - Phosphodiesterase Inhibitors***</b>	
<i>sildenafil citrate oral suspension reconstituted</i>	QL (6 ml per day); DS (30 day supply max); ST (Step Therapy required: trial of one 30 day supply fill of sildenafil citrate 20mg tablet in last 6 months); AL (Min 18 Years)
<b>*Contraceptives*</b>	
<b>*Progestin Contraceptives - Oral***</b>	
SLYND	QL (28 tablets per month); ST (Step Therapy required: 3 months in the last 6 months - norethindrone)
<b>*Corticosteroids*</b>	
<b>*Glucocorticosteroids***</b>	
ORTIKOS	QL (1 capsule per day); ST (Step Therapy required: 3 months in the last 12 months - budesonide cap 3mg DR); AL (Min 8 Years)
<b>*Cough/Cold/Allergy*</b>	
<b>*Decongestant &amp; Antihistamine***</b>	
CLARINEX-D 12 HOUR	QL (2 tablets per day); ST (Step Therapy required: any of the following in the last 1 month - Desloratadine 5mg tabs or 2.5mg/5mg ODT tabs)
<b>*Dermatologicals*</b>	
<b>*Acne Antibiotics***</b>	
AMZEEQ	QL (1gm per day); ST (Step Therapy required: BOTH of the following in the last 3 months - minocycline hcl cap 100mg AND tretinoin gel 0.04%); AL (Min 9 Years)
<b>*Acne Products***</b>	
AKLIEF	QL (45gm per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 12 months - tretinoin 0.1% or 0.05% AND tazarotene 0.1%); AL (Min 9 Years)

Step 2 Product	Step 1 Product
<b>WINLEVI</b>	QL (1x 60gm tube per month); DS (30 day supply max); ST (Step Therapy required: 60 days trial of the following in the last 12 months - tazarotene gel 0.05%, tazarotene cream 0.1%, tretinoin cream 0.1%, or tretinoin cream 0.05%); AL (Min 12 Years)
<b>*Antibiotics - Topical***</b>	
<b>XEPI</b>	QL (1x 30gm tube/box per month); ST (Step Therapy required: 3 months in the last 12 months - mupirocin ointment 2%); AL (Min 2 Years)
<b>*Antipruritics - Topical***</b>	
<i>doxepin hcl external</i>	QL (1x 45gm tube per month); ST (Step Therapy required: 2 of the following in the last 6 months - fluocinolone, triamcinolone, betamethasone dipropionate)
<b>PRUDOXIN</b>	QL (1x 45gm tube per month)
<b>ZONALON</b>	QL (1x 45gm tube per month)
<b>*Corticosteroids - Topical***</b>	
<b>CORDRAN EXTERNAL CREAM 0.05 %</b>	QL (4gm per day); DS (30 day supply max); ST (Step Therapy required: 2 of the following in the last 6 months - betamethasone, clobetasol, hydrocortisone, or triamcinolone)
<b>CORDRAN EXTERNAL TAPE</b>	QL (1 box per month); ST (Step Therapy required: 2 of the following in the last 6 months - betamethasone, clobetasol, hydrocortisone, or triamcinolone)
<i>diflorasone diacetate external</i>	QL (2gm per day); DS (30 day supply max); ST (Step Therapy required: 2 of the following in the last 6 months - betamethasone, clobetasol, hydrocortisone, or triamcinolone)
<i>flurandrenolide external cream</i>	QL (4gm per day); DS (30 day supply max); ST (Step Therapy required: 2 of the following in the last 6 months - betamethasone, clobetasol, hydrocortisone, or triamcinolone)
<i>flurandrenolide external lotion</i>	QL (4gm per day); DS (30 day supply max); ST (Step Therapy required: 2 of the following in the last 6 months - betamethasone, clobetasol, hydrocortisone, or triamcinolone)
<i>halcinonide external cream</i>	QL (2gm per day); DS (30 day supply max); ST (Step Therapy required: 2 of the following in the last 6 months - betamethasone, clobetasol, hydrocortisone, or triamcinolone)

Step 2 Product	Step 1 Product
<b>*Microtubule Inhibitors - Topical***</b>	
<b>KLISYRI</b>	QL (5 packets per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 6 months - fluorouracil 5% AND imiquimod 5% (generic for Aldara)); AL (Min 18 Years)
<b>KLISYRI (250 MG)</b>	QL (5 packets per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 6 months - fluorouracil 5% AND imiquimod 5% (generic for Aldara)); AL (Min 18 Years)
<b>KLISYRI (350 MG)</b>	QL (5 packets per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 6 months - fluorouracil 5% AND imiquimod 5% (generic for Aldara)); AL (Min 18 Years)
<b>*Rosacea Agents***</b>	
<i>ivermectin external cream</i>	QL (1x 45gm tube per month); ST (Step Therapy required: any of the following for 2 months in the last 6 months - metronidazole cream 0.75%, metronidazole gel 0.75% or 1%, or metronidazole lotion 0.75%)
<b>SOOLANTRA</b>	QL (1x 45gm tube per month)
<b>ZILXI</b>	QL (1x 30gm can per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - minocycline hcl cap 100mg AND tretinoin gel 0.04%); AL (Min 18 Years)
<b>*Diagnostic Products*</b>	
<b>*Diagnostic Tests***</b>	
<b>ACCU-CHEK AVIVA PLUS IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ACCU-CHEK GUIDE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips )
<b>ACCU-CHEK SMARTVIEW</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ACCUTREND GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)



Step 2 Product	Step 1 Product
<b>ADVANCE INTUITION TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ADVANCE MICRO-DRAW TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ADVOCATE REDI-CODE IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ADVOCATE REDI-CODE+ TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ADVOCATE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>AGAMATRIX AMP TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>AGAMATRIX JAZZ TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>AGAMATRIX PRESTO TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ASSURE 3 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ASSURE 4 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ASSURE II</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ASSURE II CHECK</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)



Step 2 Product	Step 1 Product
<b>ASSURE PLATINUM</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ASSURE PRISM MULTI TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ASSURE PRO TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>BIOTEL CARE TEST STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>blood glucose test strips 333</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>BLULINK GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CAREONE BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CARESENS N GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CARETOUCH TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CLEVER CHEK AUTO-CODE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CLEVER CHEK AUTO-CODE VOICE IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<b>CLEVER CHEK TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CLEVER CHOICE AUTO-CODE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CLEVER CHOICE MICRO TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CLEVER CHOICE NO CODING</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CLEVER CHOICE TALK SYSTEM IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CONTOUR NEXT TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CONTOUR PLUS TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CONTOUR TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>COOL BLOOD GLUCOSE TEST STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>CVS ADVANCED GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>cvs glucose meter test strips</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>cvs true metrix glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<b>D-CARE BLOOD GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>DIATHRIVE BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>DIATHRIVE GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>DIATHRIVE+ GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>DUO-CARE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASY MAX BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>easy plus ii glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASY STEP TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>easy talk blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>easy talk plus ii test strips</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASY TOUCH HEALTHPRO GLUCOSE IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASY TOUCH TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<i>easy trak blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>easy trak ii glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASYGLUCO IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASYMAX 15 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASYMAX TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASYPRO BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EASYPRO PLUS IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>element compact test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>ELEMENT TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EMBRACE BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EMBRACE EVO BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EMBRACE PRO GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<b>EMBRACE TALK GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EMBRACE WAVE BLOOD GLUCOSE IN VITRO</b>	QL (200 per month); DS (30 day supply max)
<i>eq blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>EVOLUTION AUTOCODE IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FIFTY50 GLUCOSE TEST 2.0</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA 6 CONNECT IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA 6 CONNECT/GTEL TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA D40/G31 BLOOD GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA G20 BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA GD20 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA GD50 BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA GTEL BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA TN'G ADVANCE PRO IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<b>FORA TN'G/TN'G VOICE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA V10 BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORA V30A BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORACARE GD40 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORACARE PREMIUM V10 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FORACARE TEST N GO TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FREESTYLE INSULINX TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FREESTYLE LITE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FREESTYLE PRECISION NEO TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>FREESTYLE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>ge100 blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GENULTIMATE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)



Step 2 Product	Step 1 Product
<i>ght test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCO PERFECT 3 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCOCARD 01 SENSOR PLUS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCOCARD EXPRESSION TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCOCARD SHINE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCOCARD VITAL TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCOCARD X-SENSOR</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCOCOM TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GLUCONAVII BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>glucose meter test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>gnp easy touch glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GNP TRUE METRIX GLUCOSE STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<b>GNP TRUETRACK SMART SYSTEM IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GNP TRUETRACK TEST STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GOJJI BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>GOJJI BLOOD TEST STRIP/LANCETS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>goodsense blood glucose in vitro</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>HW EMBRACE PRO GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>HW EMBRACE TALK GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>IGLUCOSE TEST STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>IHEALTH BLOOD GLUCOSE TEST STR</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>IN TOUCH BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>INFINITY BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>INFINITY VOICE IN VITRO STRIP</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)



Step 2 Product	Step 1 Product
<i>kroger blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>KROGER HEALTHPRO GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>kroger premium glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>meijer blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>meijer essential glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>MEIJER TRUETEST TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>MEIJER TRUETRACK TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>MICRODOT TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>MM BLULINK GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>MM EASY TOUCH GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>MYGLUCOHEALTH TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>NEUTEK 2TEK TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<b>NOVA MAX GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>one drop test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>OPTIUMEZ TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>PHARMACIST CHOICE AUTOCODE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>pharmacist choice no coding</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>PIP BLOOD GLUCOSE TEST STRIP</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>POCKETCHEM EZ TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>POGO AUTOMATIC TEST CARTRIDGES</b>	QL (10 boxes per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>PRECISION XTRA BLOOD GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>premium blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>pro voice v8/v9 glucose</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>PRODIGY NO CODING BLOOD GLUC IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<b>PTS PANELS EGLU TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>QUICK TOUCH BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips )
<b>QUICKTEK TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>QUINTET AC BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>QUINTET BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>REFUAH PLUS BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RELION BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RELION CONFIRM/MICRO TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RELION GLUCOSE TEST STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips )
<b>RELION PREMIER TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RELION PRIME TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RELION TRUE METRIX TEST STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

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Step 2 Product	Step 1 Product
<b>RELION ULTIMA TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>REXALL BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RIGHTEST GS100 BLOOD GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RIGHTEST GS300 BLOOD GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RIGHTEST GS550 BLOOD GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RIGHTEST GT333 BLOOD GLUCOSE IN VITRO</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>RIGHTEST GT333 GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>SMART SENSE PREMIUM TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>SMART SENSE VALUE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>SMARTEST BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>SOLUS V2 TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>SUPREME TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)

Step 2 Product	Step 1 Product
<i>tgt blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>true focus blood glucose strip</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>TRUE METRIX BLOOD GLUCOSE TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>TRUE METRIX PRO BLOOD GLUCOSE</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>TRUETEST TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>TRUETRACK TEST</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>UNISTRIP1 GENERIC</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<i>verasens blood glucose test</i>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>VIVAGUARD INO TEST STRIPS</b>	QL (200 per month); DS (30 day supply max); ST (Step Therapy required: BOTH of the following in the last 3 months - 60 days insulin AND 1 fill OneTouch test strips)
<b>*Gastrointestinal Agents - Misc.*</b>	
<b>*Cic Agents - Guanylate Cyclase-C (Gc-C) Agonists***</b>	
<b>TRULANCE</b>	QL (2 tablets per day); ST (Step Therapy required: 1 fill in the last 6 months - Linzess); AL (Min 18 Years)
<b>*Gastrointestinal Chloride Channel Activators***</b>	
<b>AMITIZA</b>	QL (2 capsules per day); ST (Step Therapy required: trial of generic lubiprostone AND Linzess for at least 1 fill in the last 6 months); AL (Min 18 Years)

Step 2 Product	Step 1 Product
<b>*Gout Agents*</b>	
<b>*Gout Agents***</b>	
<i>febuxostat</i>	QL (1 tablet per day); ST (Step Therapy required: any of the following for 3 months in the last 6 months - allopurinol 100mg or 300mg tab); AL (Min 18 Years)
<b>*Hematopoietic Agents*</b>	
<b>*Cytotoxic Agents***</b>	
<b>DROXIA</b>	QL (1 capsule per day); DS (30 day supply max); ST (Step Therapy required: BOTH of the following for 3 months each in the last 12 months - Siklos 100mg or 1000mg tab AND hydroxyurea 500mg cap); AL (Min 18 Years)
<b>*Hypnotics/Sedatives/Sleep Disorder Agents*</b>	
<b>*Hypnotics - Tricyclic Agents***</b>	
<i>doxepin hcl oral tablet 3 mg</i>	QL (1 tablet per day); ST (Step Therapy required: 3 months in the last 12 months - doxepin hcl 10mg capsule); AL (Min 18 Years)
<i>doxepin hcl oral tablet 6 mg</i>	QL (1 tablet per day); ST (Step Therapy required: 3 months in the last 12 months - doxepin hcl 10mg cap); AL (Min 18 Years)
<b>*Orexin Receptor Antagonists***</b>	
<b>BELSOMRA</b>	QL (1 tablet per day); ST (Step Therapy required: 2 of the following in the last 6 months - eszopiclone tab, zaleplon cap, or rozerem tab); AL (Min 18 Years)
<b>DAYVIGO</b>	QL (1 tablet per day); ST (Step Therapy required: 2 of the following in the last 6 months - eszopiclone tab, zaleplon cap, or rozerem tab); AL (Min 18 Years)
<b>QUVIVIQ</b>	QL (1 tablet per day); ST (Step Therapy required: 3 of the following for 1 month each in the last 12 months - eszopiclone, ramelteon, zaleplon, or zolpidem)
<b>*Migraine Products*</b>	
<b>*Selective Serotonin Agonists 5-Ht(1)***</b>	
<i>frovatriptan succinate</i>	QL (20 tabs per month); ST (Step Therapy required: 2 of the following in the last 12 months - almotriptan, eletriptan, naratriptan, rizatriptan, sumatriptan, or zolmitriptan)



Step 2 Product	Step 1 Product
<b>*Musculoskeletal Therapy Agents*</b>	
<b>*Central Muscle Relaxants***</b>	
<i>chlorzoxazone oral tablet 375 mg, 750 mg</i>	QL (4 tablets per day); ST (Step Therapy required: 1 fill in the last 3 months - chlorzoxazone 500mg tab); AL (Min 18 Years)
<b>LORZONE</b>	QL (4 tablets per day); ST (Step Therapy required: 1 fill in the last 3 months - chlorzoxazone 500mg tab); AL (Min 18 Years)
<b>*Ophthalmic Agents*</b>	
<b>*Miotics - Direct Acting***</b>	
<b>QLOSI</b>	QL (1 vial per day); ST (Step Therapy required: 1 fill in the last 6 months - pilocarpine 1%); AL (Min 18 Years)
<b>VUITY</b>	QL (one 2.5ml bottle per month); ST (Step Therapy required: 1 fill in the last 6 months - pilocarpine 1%); AL (Min 18 Years)
<b>*Prostaglandins - Ophthalmic***</b>	
<b>LUMIGAN OPHTHALMIC SOLUTION 0.01 %</b>	ST (Step Therapy required: 60 day trial of bimatoprost 0.03% in the last 6 months)
<b>VYZULTA</b>	QL (1x 2.5ml bottle per month); ST (Step Therapy required: through 60 days trial of either latanoprost (generic Xalatan) OR bimatoprost 0.03% in the last 6 months); AL (Min 17 Years)
<b>*Psychotherapeutic And Neurological Agents - Misc.*</b>	
<b>*Cholinomimetics - Ache Inhibitors***</b>	
<b>ADLARITY</b>	ST (Step Therapy required: 2 months in the last 3 months - donepezil)
<b>*Postherpetic Neuralgia (Phn)/Neuropathic Pain Agents***</b>	
<i>pregabalin er</i>	QL (1 tablet per day); ST (Step Therapy required: any of the following in the last 6 months - pregabalin (generic Lyrica) or Lyrica)
<b>*Ulcer Drugs/Antispasmodics/Anticholinergics*</b>	
<b>*Quaternary Anticholinergics***</b>	
<b>DARTISLA ODT</b>	QL (4 tablets per day); ST (Step Therapy required: ONE from EACH of the following in the last 3 months: 1) rabeprazole or pantoprazole AND 2) glycopyrrolate (1mg or 2mg tablet)); AL (Min 18 Years)
<b>*Ulcer Anti-Infective W/ Proton Pump Inhibitors***</b>	
<b>TALICIA</b>	QL (12 capsules per day); ST (Step Therapy required: ALL of the following in the last 3 months - clarithromycin, amoxicillin, AND pantoprazole); AL (Min 18 Years)

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10	27	<i>zileuton er</i> .....	3
<i>ivermectin</i> .....	QUINTET BLOOD GLUCOSE TEST .....	ZILXI .....	15
15	27	ZIMHI .....	11
KAPSPARGO SPRINKLE .....	QUVIVIQ .....	ZITUVIMET .....	8
12	30	ZITUVIMET XR .....	9
KARBINAL ER .....	REFUAH PLUS BLOOD GLUCOSE TEST .....	ZONALON .....	14
11	27	ZYFLO .....	3
KAZANO .....	RELION BLOOD GLUCOSE TEST .....	ZYPITAMAG .....	12
8	27		
KLISYRI .....	RELION CONFIRM/MICRO TEST .....		
15	27		
KLISYRI (250 MG) .....	RELION GLUCOSE TEST STRIPS .....		
15	27		
KLISYRI (350 MG) .....	RELION PREMIER TEST .....		
15	27		
KOMBIGLYZE XR .....	RELION PRIME TEST .....		
8	27		
<i>kroger blood glucose test</i> .....	RELION TRUE METRIX TEST STRIPS .....		
25	27		
KROGER HEALTHPRO GLUCOSE TEST .....	RELION ULTIMA TEST .....		
25	28		
<i>kroger premium glucose test</i> .....	REXALL BLOOD GLUCOSE TEST .....		
25	28		
LORZONE .....	RIGHTEST GS100 BLOOD GLUCOSE .....		
31	28		
LUMIGAN .....	RIGHTEST GS300 BLOOD GLUCOSE .....		
31	28		
<i>meijer blood glucose test</i> .....	RIGHTEST GS550 BLOOD GLUCOSE .....		
25	28		
<i>meijer essential glucose test</i> .....	RIGHTEST GT333 BLOOD GLUCOSE .....		
25	28		
MEIJER TRUETEST TEST .....	RIGHTEST GT333 GLUCOSE TEST .....		
25	28		
MEIJER TRUETRACK TEST .....	<i>saxagliptin hcl</i> .....		
25	8		
MICRODOT TEST .....	<i>saxagliptin-metformin er</i> .....		
25	8		
MM BLULINK GLUCOSE TEST .....	SEGLUROMET .....		
25	11		
MM EASY TOUCH GLUCOSE .....	SEMGLEE .....		
25	9		
MYGLUCOHEALTH TEST .....	SEMGLEE (YFGN) .....		
25	9		
NESINA .....	<i>sildenafil citrate</i> .....		
8	13		
NEUTEK 2TEK TEST .....	<i>sitagliptin base-metformin hcl</i> .....		
25	8		
NEXLETOL .....	SLYND .....		
12	13		
NEXLIZET .....	SMART SENSE PREMIUM TEST .....		
11	28		
NOVA MAX GLUCOSE TEST .....	SMART SENSE VALUE TEST .....		
26	28		
NOVOLOG PENFILL .....			
9			
<i>one drop test</i> .....			
26			
ONGLYZA .....			
8			
OPTIUMEZ TEST .....			
26			
ORTIKOS .....			
13			
OSENI .....			
9			
PHARMACIST CHOICE AUTOCODE .....			
26			



An Independent Licensee of the Blue Cross Blue Shield Association

# Notice of Nondiscrimination

## Discrimination Is Against the Law

**Blue Cross® Blue Shield® of Arizona (AZ Blue)** complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). **AZ Blue** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

### **AZ Blue:**

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that **AZ Blue** 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:

### **Section 1557 Coordinator**

**P.O. Box 13466**

**Phoenix, AZ 85002-3466; Call 602-864-2288, TTY: 711**

or email us at [crc@azblue.com](mailto:crc@azblue.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **AZ Blue Section 1557 Coordinator** 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, 1-800-537-7697 (TDD)

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

This notice is available at AZ Blue's website: [azblue.com/nondiscrimination-notice](http://azblue.com/nondiscrimination-notice).



Un licenciatario independiente de Blue Cross Blue Shield Association

## Aviso de no discriminación

La discriminación es ilegal

**Blue Cross® Blue Shield® of Arizona (AZ Blue)** cumple con las leyes federales de derechos civiles vigentes y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad ni sexo (de conformidad con el alcance de la discriminación sexual descrita en la Sección 92.101[a][2] del Título 45 del Código de Regulaciones Federales [CFR]) (o sexo, que incluye las características sexuales, como rasgos intersexuales, embarazo o condiciones relacionadas, orientación sexual, identidad de género y estereotipos sexuales). **AZ Blue** no excluye a las personas ni las trata de manera menos favorable por motivos de raza, color, nacionalidad, edad, discapacidad ni sexo.

### **AZ Blue:**

- Brinda a las personas con discapacidades modificaciones razonables y ayudas y servicios auxiliares gratuitos y apropiados para comunicarse de manera eficaz con nosotros, tales como:
  - Intérpretes de lenguaje de señas calificados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Ofrece servicios gratuitos de asistencia lingüística a personas cuyo idioma principal no es el inglés, que pueden incluir:
  - Intérpretes calificados.
  - Información escrita en otros idiomas

Si necesita modificaciones razonables, ayudas y servicios auxiliares apropiados o servicios de asistencia lingüística, llame al 602-864-4884 para español y al 1-877-475-4799 para todos los demás idiomas y otras ayudas y servicios.

Si considera que **AZ Blue** no ha proporcionado estos servicios o ha discriminado de cualquier otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante:

### **Section 1557 Coordinator**

**P.O. Box 13466**

**Phoenix, AZ 85002-3466; Call 602-864-2288, TTY: 711**

o bien, envíenos un correo electrónico a [crc@azblue.com](mailto:crc@azblue.com)

Puede presentar una queja en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para presentar una queja, el **Coordinador de la Sección 1557 de AZ Blue** está disponible para ayudar.

También puede presentar un reclamo de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de manera electrónica a través del Portal de reclamos de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o teléfono a:

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

Los formularios de reclamos están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>. Este aviso está disponible en el sitio web de AZ Blue: [azblue.com/nondiscrimination-notice](http://azblue.com/nondiscrimination-notice).

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

**Spanish:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

**Navajo:** Diné bee yániit'i'gogo, saad bee aná'awo' bee áka'anída'awo'ít'á'á jiiik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'á'á ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'i'ígíí éí t'á'á jiiik'eh hóló. Kohjí' 1-877-475-4799.

**Chinese Simplified:** 如果您说[中文],我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务,以无障碍格式提供信息。致电 1-877-475-4799。

**Chinese Traditional:** 如果您說[中文],我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務,以無障礙格式提供資訊。請致電 1-877-475-4799。

**Tagalog:** Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

**French:** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

**Vietnamese:** Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

**German:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

**Korean:** 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

**Russian:** Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

### Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

**Hindi:** यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-877-475-4799 ।

### Farsi (Persian)

همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. فارسی اگر توجه: 1-877-475-4799 با شماره دسترس، به‌طور رایگان موجود می‌باشند.

**Thai:** หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799 หรือปรึกษาผู้ให้บริการของคุณ”

**Japanese:** 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799。