

## STEP THERAPY CRITERIA

This list is current as of November 1, 2024, and pertains to the following formularies:

2024 Pharmacy Benefit Dimensions PDP offered by Niagara County Formulary D0457 - 0464	Version 20
2024 Pharmacy Benefit Dimensions PDP offered by Niagara County Formulary D0465	Version 20

In some cases, we require that you first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. This document contains the Step Therapy protocols that are associated with the formularies listed above.

If you have any questions, please contact our Medicare Member Services Department at 1-800-667-5936 or, for TTY users 711, October 1<sup>st</sup> – March 31<sup>st</sup>: Monday through Sunday from 8 a.m. to 8 p.m. ET, April 1<sup>st</sup> – September 30<sup>th</sup>: Monday through Friday from 8 a.m. to 8 p.m. ET.

Pharmacy Benefit Dimensions is a subsidiary of Independent Health. Independent Health is a PDP with a Medicare contract. Enrollment in Pharmacy Benefit Dimensions PDP depends on contract renewal between Independent Health and CMS.

The formulary may change at any time. You will receive notice when necessary.

# Aliskiren Step

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## Products Affected

- *aliskiren fumarate tablet 150 mg oral*
- *aliskiren fumarate tablet 300 mg oral*

## Details

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Criteria	Prior prescription history of an ARB to obtain any products containing aliskiren.
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# Eucrisa Step

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## Products Affected

- EUCRISA OINTMENT 2 % EXTERNAL

## Details

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<b>Criteria</b>	Prior prescription history positive for the use of either a topical corticosteroid or topical calcineurin inhibitor.
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# Hectoral Step Therapy

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## Products Affected

- *doxercalciferol capsule 0.5 mcg oral*
- *doxercalciferol capsule 1 mcg oral*
- *doxercalciferol capsule 2.5 mcg oral*

## Details

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<b>Criteria</b>	Prior Prescription history includes past use of calcitriol.
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# Incretin Mimetic Step

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## Products Affected

- *liraglutide solution pen-injector 18 mg/3ml subcutaneous*
- MOUNJARO SOLUTION PEN-INJECTOR 10 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5ML SUBCUTANEOUS
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/3ML SUBCUTANEOUS
- OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3ML SUBCUTANEOUS
- OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3ML SUBCUTANEOUS
- RYBELSUS TABLET 14 MG ORAL
- RYBELSUS TABLET 3 MG ORAL
- RYBELSUS TABLET 7 MG ORAL
- TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML SUBCUTANEOUS
- VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS

## Details

<b>Criteria</b>	Requires the use of another medication that is FDA-approved for the treatment of type 2 diabetes first. If the incretin mimetic is being used for risk reduction of major cardiovascular events in adults with type 2 diabetes and established cardiovascular disease, this criterion does not apply.
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# Pregabalin ER Step

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## Products Affected

- *pregabalin er tablet extended release 24 hour 165 mg oral*
- *pregabalin er tablet extended release 24 hour 330 mg oral*
- *pregabalin er tablet extended release 24 hour 82.5 mg oral*

## Details

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<b>Criteria</b>	Requires the use of an immediate-release pregabalin product first.
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# Qelbree Step

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## Products Affected

- QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL
- QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL
- QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL

## Details

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<b>Criteria</b>	Requires the use of generic atomoxetine first.
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# Talicia Step

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## Products Affected

- TALICIA CAPSULE DELAYED RELEASE 250-12.5-10 MG  
ORAL

## Details

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<b>Criteria</b>	Prior prescription history positive for the use of an empiric (standard first-line) Helicobacter pylori regimen.
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# Topical Rosacea Step

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## Products Affected

- EPSOLAY CREAM 5 % EXTERNAL
- FINACEA FOAM 15 % EXTERNAL

## Details

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<b>Criteria</b>	Prior prescription history of at least one other topical rosacea medication used for papules/pustules including azelaic acid gel, ivermectin cream, or metronidazole products.
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# Tramadol ER

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## Products Affected

- *tramadol hcl (er biphasic) tablet extended release 24 hour 100 mg oral*
- *tramadol hcl (er biphasic) tablet extended release 24 hour 200 mg oral*
- *tramadol hcl (er biphasic) tablet extended release 24 hour 300 mg oral*
- *tramadol hcl er tablet extended release 24 hour 100 mg oral*
- *tramadol hcl er tablet extended release 24 hour 200 mg oral*
- *tramadol hcl er tablet extended release 24 hour 300 mg oral*

## Details

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<b>Criteria</b>	Requires the use of tramadol immediate release first
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# Uloric Step

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## Products Affected

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

## Details

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<b>Criteria</b>	Requires allopurinol prior to use.
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# Xphozah Step

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## Products Affected

- XPHOZAH TABLET 20 MG ORAL
- XPHOZAH TABLET 30 MG ORAL

## Details

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<b>Criteria</b>	Requires the maintenance use of a traditional phosphate binder such as calcium acetate, ferric citrate, lanthanum carbonate, sevelamer, or sucroferric oxyhydroxide. This step therapy is required at each fill.
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# ZEMPLAR STEP THERAPY

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## Products Affected

- RAYALDEE CAPSULE EXTENDED RELEASE 30 MCG  
ORAL

## Details

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Criteria	Prior Prescription history includes past use of calcitriol.
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