HIGHMARK

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Step Therapy Detail

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Selected Formulary: 2026 Highmark Health Options Duals Select | CMS Formulary ID: 00026454 | CMS Version: 18

ST Group	Product	Type	Step Order	Algorithm
AMANTADINE (GOCOVRI ER CAPSULE)	Amantadine HCl Capsule 100 MG Oral	ST applies	1	This prescription benefit provides coverage for Gocovri (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for immediate release amantadine. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
AMANTADINE (GOCOVRI ER CAPSULE)	Amantadine HCl Solution 50 MG/5ML Oral	ST applies	1	This prescription benefit provides coverage for Gocovri (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for immediate release amantadine. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
AMANTADINE (GOCOVRI ER CAPSULE)	Amantadine HCl Tablet 100 MG Oral	ST applies	1	This prescription benefit provides coverage for Gocovri (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for immediate release amantadine. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
AMANTADINE (GOCOVRI ER CAPSULE)	Gocovri Capsule Extended Release 24 Hour 137 MG Oral	ST applies	2	This prescription benefit provides coverage for Gocovri (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for immediate release amantadine. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

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AMANTADINE (GOCOVRI ER CAPSULE)	Gocovri Capsule Extended Release 24 Hour 68.5 MG Oral	ST applies	2	This prescription benefit provides coverage for Gocovri (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for immediate release amantadine. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Solution 1 MG/ML Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet 10 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet 15 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet 2 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

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ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet 20 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet 30 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet 5 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet Dispersible 10 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	ARIPiprazole Tablet Dispersible 15 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

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ARIPIPRAZOLE (OPIPZA)	Opipza Film 10 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	Opipza Film 2 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
ARIPIPRAZOLE (OPIPZA)	Opipza Film 5 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for Opipza (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic aripiprazole. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
CRISABOROLE (EUCRISA)	Pimecrolimus Cream 1 % External	ST applies	1	This prescription benefit provides coverage for topical crisaborole (Eucrisa) (without requiring a coverage review process) in members under the age of 2 or in situations where the member has paid claims history during the prior 12 months for topical pimecrolimus or topical tacrolimus. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
CRISABOROLE (EUCRISA)	Tacrolimus Ointment 0.03 % External	ST applies	1	This prescription benefit provides coverage for topical crisaborole (Eucrisa) (without requiring a coverage review process) in members under the age of 2 or in situations where the member has paid claims history during the prior 12 months for topical pimecrolimus or topical tacrolimus. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
CRISABOROLE (EUCRISA)	Tacrolimus Ointment 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical crisaborole (Eucrisa) (without requiring a coverage review process) in members under the age of 2 or in situations where the member has paid claims history during the prior 12 months for topical pimecrolimus or topical tacrolimus. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
CRISABOROLE (EUCRISA)	Eucrisa Ointment 2 % External	ST applies	2	This prescription benefit provides coverage for topical crisaborole (Eucrisa) (without requiring a coverage review process) in members under the age of 2 or in situations where the member has paid claims history during the prior 12 months for topical pimecrolimus or topical tacrolimus. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	Lansoprazole Capsule Delayed Release 15 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	Lansoprazole Capsule Delayed Release 30 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	Omeprazole Capsule Delayed Release 10 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

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DEXLANSOPRAZOLE	Omeprazole Capsule Delayed Release 20 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	Omeprazole Capsule Delayed Release 40 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	Pantoprazole Sodium Tablet Delayed Release 20 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	Pantoprazole Sodium Tablet Delayed Release 40 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	RABEprazole Sodium Tablet Delayed Release 20 MG Oral	ST applies	1	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

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DEXLANSOPRAZOLE	Dexlansoprazole Capsule Delayed Release 30 MG Oral	ST applies	2	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
DEXLANSOPRAZOLE	Dexlansoprazole Capsule Delayed Release 60 MG Oral	ST applies	2	This prescription benefit provides coverage for dexlansoprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
ESOMEPRAZOLE	Esomeprazole Magnesium Capsule Delayed Release 20 MG Oral	ST applies	2	This prescription benefit provides coverage for esomeprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
ESOMEPRAZOLE	Esomeprazole Magnesium Capsule Delayed Release 40 MG Oral	ST applies	2	This prescription benefit provides coverage for esomeprazole (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 formulary PPI's such as omeprazole, pantoprazole, lansoprazole, rabeprazole. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
FEBUXOSTAT (ULORIC)	Allopurinol Tablet 100 MG Oral	ST applies	1	This prescription benefit provides coverage for Febuxostat (Uloric) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for Allopurinol. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

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FEBUXOSTAT (ULORIC)	Allopurinol Tablet 300 MG Oral	ST applies	1	This prescription benefit provides coverage for Febuxostat (Uloric) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for Allopurinol. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
FEBUXOSTAT (ULORIC)	Febuxostat Tablet 40 MG Oral	ST applies	2	This prescription benefit provides coverage for Febuxostat (Uloric) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for Allopurinol. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
FEBUXOSTAT (ULORIC)	Febuxostat Tablet 80 MG Oral	ST applies	2	This prescription benefit provides coverage for Febuxostat (Uloric) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for Allopurinol. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
FIDAXOMICIN (DIFICID)	Vancomycin HCl Capsule 125 MG Oral	ST applies	1	This prescription benefit provides coverage for Dificid (fidaxomicin) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for oral vancomycin. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
FIDAXOMICIN (DIFICID)	Vancomycin HCl Capsule 250 MG Oral	ST applies	1	This prescription benefit provides coverage for Dificid (fidaxomicin) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for oral vancomycin. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

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FIDAXOMICIN (DIFICID)	Dificid Suspension Reconstituted 40 MG/ML Oral	ST applies	2	This prescription benefit provides coverage for Dificid (fidaxomicin) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for oral vancomycin. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
FIDAXOMICIN (DIFICID)	Dificid Tablet 200 MG Oral	ST applies	2	This prescription benefit provides coverage for Dificid (fidaxomicin) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for oral vancomycin. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
LACOSAMIDE (MOTPOLY XR) CAPSULE	Lacosamide Solution 10 MG/ML Oral	ST applies to new starts only	1	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
LACOSAMIDE (MOTPOLY XR) CAPSULE	Lacosamide Tablet 100 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
LACOSAMIDE (MOTPOLY XR) CAPSULE	Lacosamide Tablet 150 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

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LACOSAMIDE (MOTPOLY XR) CAPSULE	Lacosamide Tablet 200 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
LACOSAMIDE (MOTPOLY XR) CAPSULE	Lacosamide Tablet 50 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
LACOSAMIDE (MOTPOLY XR) CAPSULE	Motpoly XR Capsule Extended Release 24 Hour 100 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
LACOSAMIDE (MOTPOLY XR) CAPSULE	Motpoly XR Capsule Extended Release 24 Hour 150 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
LACOSAMIDE (MOTPOLY XR) CAPSULE	Motpoly XR Capsule Extended Release 24 Hour 200 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for lacosamide (Motpoly XR capsule (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic lacosamide. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

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MOMETASONE FUROATE NASAL SPRAY	Flunisolide Solution 25 MCG/ACT (0.025%) Nasal	ST applies	1	This prescription benefit provides coverage for mometasone furoate nasal spray (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for fluticasone or flunisolide nasal spray. An exception to previous therapy is provided for a diagnosis of nasal polyps, which requires no previous therapy. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
MOMETASONE FUROATE NASAL SPRAY	Fluticasone Propionate Suspension 50 MCG/ACT Nasal	ST applies	1	This prescription benefit provides coverage for mometasone furoate nasal spray (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for fluticasone or flunisolide nasal spray. An exception to previous therapy is provided for a diagnosis of nasal polyps, which requires no previous therapy. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
MOMETASONE FUROATE NASAL SPRAY	Mometasone Furoate Suspension 50 MCG/ACT Nasal	ST applies	2	This prescription benefit provides coverage for mometasone furoate nasal spray (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for fluticasone or flunisolide nasal spray. An exception to previous therapy is provided for a diagnosis of nasal polyps, which requires no previous therapy. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Atorvastatin Calcium Tablet 10 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

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NEXLETOL (BEMPEDOIC ACID)	Atorvastatin Calcium Tablet 20 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Atorvastatin Calcium Tablet 40 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Atorvastatin Calcium Tablet 80 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Lovastatin Tablet 10 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Lovastatin Tablet 20 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

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NEXLETOL (BEMPEDOIC ACID)	Lovastatin Tablet 40 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Pravastatin Sodium Tablet 10 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Pravastatin Sodium Tablet 20 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Pravastatin Sodium Tablet 40 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Pravastatin Sodium Tablet 80 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

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NEXLETOL (BEMPEDOIC ACID)	Rosuvastatin Calcium Tablet 10 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Rosuvastatin Calcium Tablet 20 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Rosuvastatin Calcium Tablet 40 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Rosuvastatin Calcium Tablet 5 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Simvastatin Tablet 10 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
NEXLETOL (BEMPEDOIC ACID)	Simvastatin Tablet 20 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Simvastatin Tablet 40 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Simvastatin Tablet 5 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Simvastatin Tablet 80 MG Oral	ST applies	1	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
NEXLETOL (BEMPEDOIC ACID)	Nexletol Tablet 180 MG Oral	ST applies	2	This prescription benefit provides coverage for Nexletol (bempedoic acid) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for 2 statins such as atorvastatin, rosuvastatin, simvastatin, lovastatin, pravastatin. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Betamethasone Dipropionate Aug Cream 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Dipropionate Aug Gel 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Dipropionate Aug Lotion 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Dipropionate Aug Ointment 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Betamethasone Dipropionate Cream 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Dipropionate Lotion 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Dipropionate Ointment 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Valerate Cream 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Betamethasone Valerate Foam 0.12 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Valerate Lotion 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Betamethasone Valerate Ointment 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clobetasol Propionate E Cream 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Clobetasol Propionate Foam 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clobetasol Propionate Gel 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clobetasol Propionate Liquid 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clobetasol Propionate Lotion 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Clobetasol Propionate Ointment 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clobetasol Propionate Shampoo 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clobetasol Propionate Solution 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clodan Shampoo 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Clotrimazole-Betamethasone Cream 1-0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Clotrimazole-Betamethasone Lotion 1-0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Desonide Cream 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Desonide Lotion 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Desonide Ointment 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Desoximetasone Cream 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Desoximetasone Cream 0.25 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Desoximetasone Gel 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Desoximetasone Ointment 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Desoximetasone Ointment 0.25 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Fluocinolone Acetonide Body Oil 0.01 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Fluocinolone Acetonide Cream 0.01 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Fluocinolone Acetonide Cream 0.025 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Fluocinolone Acetonide Ointment 0.025 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Fluocinolone Acetonide Scalp Oil 0.01 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Fluocinolone Acetonide Solution 0.01 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Fluocinonide Gel 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Fluocinonide Ointment 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Fluocinonide Solution 0.05 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Hydrocortisone Valerate Cream 0.2 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Hydrocortisone Valerate Ointment 0.2 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Mometasone Furoate Cream 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Mometasone Furoate Ointment 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Mometasone Furoate Solution 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Nystatin-Triamcinolone Cream 100000-0.1 UNIT/GM-% External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Nystatin-Triamcinolone Ointment 100000-0.1 UNIT/GM-% External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Triamcinolone Acetonide Cream 0.025 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Triamcinolone Acetonide Cream 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Triamcinolone Acetonide Cream 0.5 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Triamcinolone Acetonide Lotion 0.025 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Triamcinolone Acetonide Lotion 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Triamcinolone Acetonide Ointment 0.025 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
PIMECROLIMUS	Triamcinolone Acetonide Ointment 0.1 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Triamcinolone Acetonide Ointment 0.5 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
PIMECROLIMUS	Triderm Cream 0.5 % External	ST applies	1	This prescription benefit provides coverage for topical pimecrolimus (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older. Benefit coverage for situations in which none or one of the above qualifications exist in history is determined through the exception review process.
SYMPAZAN	cloBAZam Suspension 2.5 MG/ML Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Sympazan (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic clobazam. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
SYMPAZAN	cloBAZam Tablet 10 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Sympazan (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic clobazam. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
SYMPAZAN	cloBAZam Tablet 20 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Sympazan (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic clobazam. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
SYMPAZAN	Sympazan Film 10 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for Sympazan (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic clobazam. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
SYMPAZAN	Sympazan Film 20 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for Sympazan (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic clobazam. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
SYMPAZAN	Sympazan Film 5 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for Sympazan (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic clobazam. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
TRAZODONE (RALDESY)	traZODone HCl Tablet 100 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Raldesy (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic trazodone. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
TRAZODONE (RALDESY)	traZODone HCl Tablet 150 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Raldesy (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic trazodone. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
TRAZODONE (RALDESY)	traZODone HCl Tablet 300 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Raldesy (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic trazodone. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
TRAZODONE (RALDESY)	traZODone HCl Tablet 50 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for Raldesy (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic trazodone. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
TRAZODONE (RALDESY)	Raldesy Solution 10 MG/ML Oral	ST applies to new starts only	2	This prescription benefit provides coverage for Raldesy (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for generic trazodone. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
VENLAFAXINE BESYLATE	Venlafaxine HCl ER Capsule Extended Release 24 Hour 150 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl ER Capsule Extended Release 24 Hour 37.5 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl ER Capsule Extended Release 24 Hour 75 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl ER Tablet Extended Release 24 Hour 150 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl ER Tablet Extended Release 24 Hour 225 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
VENLAFAXINE BESYLATE	Venlafaxine HCl ER Tablet Extended Release 24 Hour 37.5 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl ER Tablet Extended Release 24 Hour 75 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl Tablet 100 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl Tablet 25 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl Tablet 37.5 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.

ST Group	Product	Type	Step Order	Algorithm
VENLAFAXINE BESYLATE	Venlafaxine HCl Tablet 50 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine HCl Tablet 75 MG Oral	ST applies to new starts only	1	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
VENLAFAXINE BESYLATE	Venlafaxine Besylate ER Tablet Extended Release 24 Hour 112.5 MG Oral	ST applies to new starts only	2	This prescription benefit provides coverage for venlafaxine besylate (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for venlafaxine hydrochloride extended release. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.