



Step Therapy Detail

Updated on 4/1/2026

Selected Formulary: 2026 Medicare AssuredSM | CMS Formulary ID: 00026454 | CMS Version: 10

| 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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| ARIPIRAZOLE (OIPZA) | 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. |
| ARIPIRAZOLE (OIPZA) | 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. |
| ARIPIRAZOLE (OIPZA) | 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. |
| ARIPIRAZOLE (OIPZA) | 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. |
| ARIPIRAZOLE (OIPZA) | 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. |
| CHENODIOL (CHENODAL) | Ursodiol Capsule 300 MG Oral | ST applies | 1 | This prescription benefit provides coverage for Chenodiol (Chenodal) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for ursodiol. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process. |
| CHENODIOL (CHENODAL) | Ursodiol Tablet 250 MG Oral | ST applies | 1 | This prescription benefit provides coverage for Chenodiol (Chenodal) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for ursodiol. 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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| CHENODIOL (CHENODAL) | Ursodiol Tablet 500 MG Oral | ST applies | 1 | This prescription benefit provides coverage for Chenodiol (Chenodal) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for ursodiol. Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process. |
| CHENODIOL (CHENODAL) | Chenodal Tablet 250 MG Oral | ST applies | 2 | This prescription benefit provides coverage for Chenodiol (Chenodal) (without requiring a coverage review process) in situations where the member has paid claims history during the prior 12 months for ursodiol. 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. |
| 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. |

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| 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. |

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| 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. |
| 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. |

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| 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. |
| 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. |

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| 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. |
| 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. |

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| 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. |
| 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. |

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| 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. |
| 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. |

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| 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. |
| 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. |

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| 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. |
| 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. |

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| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|---------------------------|-------------------------------|------------|------------|---|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|---------------------------|--|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|--|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|--|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|--|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|--|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|--|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|---|------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|--------------|------------------------------------|-------------------------------|------------|--|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|---------------------|----------------------------------|-------------------------------|------------|---|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|----------------------|--|-------------------------------|------------|---|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|----------------------|---|-------------------------------|------------|---|
| 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. |
| 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. |

| ST Group | Product | Type | Step Order | Algorithm |
|----------------------|---|-------------------------------|------------|---|
| 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. |
| 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. |