HealthPartners, Inc.
2012 Medicare Part D Formulary ID 12129, Version 17
Step Therapy Criteria

Step Therapy Group Desc	Drugs Name	Step Therapy Criteria
AMITIZA	AMITIZA	PRIOR USE OF POLYETHELENE GLYCOL OR LACTULOSE WITHIN THE PREVIOUS 12 MONTHS.
ARB THERAPY	AVALIDE | AVAPRO | DIOVAN | DIOVAN HCT | IRBESARTAN | IRBESARTAN-HYDROCHLOROTHIAZIDE	PRIOR USE OF LOSARTAN, LOSARTAN HCTZ, OR A FORMULARY ACE INHIBITOR OR ACE INHIBITOR COMBINATION (SUCH AS BENAZEPRIL, CAPTOPRIL, ENALAPRIL, LISINOPRIL, RAMIPRIL, BENAZEPRIL-HCTZ OR LISINOPRIL-HCTZ) WITHIN THE PREVIOUS 12 MONTHS.
BISPHOSPHONATE THERAPY	ACTONEL | ATELVIA | FOSAMAX | FOSAMAX PLUS D	PRIOR USE OF GENERIC ALENDRONATE WITHIN THE PREVIOUS 12 MONTHS.
CELEBREX	CELEBREX	PRIOR USE OF ONE OTHER FORMULARY PRESCRIPTION NON-STEROIDAL ANTI-INFLAMMATORY MEDICATION (SUCH AS FLURBIPROFEN, IBUPROFEN, MELOXICAM, NAPROXEN, PIROXICAM, SULINDAC, TOLMETIN OR OTHER NSAIDS) WITHIN THE PREVIOUS 12 MONTHS.
COREG CR	COREG CR	PRIOR USE OF GENERIC CARVEDILOL REGULAR RELEASE WITHIN THE PREVIOUS 12 MONTHS.
CYMBALTA	CYMBALTA	PRIOR USE OF A GENERIC FORMULARY SSRI MEDICATION (SUCH AS CITALOPRAM, FLUOXETINE, FLUVOXAMINE, PAROXETINE HCL OR SERTRALINE), OR GENERIC BUPROPION, OR GENERIC MIRTAZAPINE, OR GABAPENTIN, OR A NON-STEROIDAL ANTI-INFLAMMATORY MEDICATION (SUCH AS FLURBIPROFEN, IBUPROFEN, MELOXICAM, NAPROXEN, PIROXICAM, SULINDAC, TOLMETIN OR OTHER NSAIDS) WITHIN THE PREVIOUS 12 MONTHS.

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LEVEMIR	LEVEMIR	PRIOR USE OF LANTUS WITHIN THE PREVIOUS 12 MONTHS.
LIDODERM	LIDODERM	PRIOR USE OF GABAPENTIN WITHIN THE PREVIOUS 12 MONTHS.
LOVAZA	LOVAZA	PRIOR USE OF GEMFIBROZIL OR A FORMULARY FENOFIBRATE (SUCH AS TRICOR OR GENERIC FENOFIBRATE) WITHIN THE PREVIOUS 12 MONTHS.
LYRICA	LYRICA	PRIOR USE OF GABAPENTIN WITHIN THE PREVIOUS 12 MONTHS.
MULTIPLE SCLEROSIS DRUG THERAPY	AVONEX | AVONEX ADMINISTRATION PACK | EXTAVIA	PRIOR USE OF COPAXONE AND REBIF WITHIN THE PREVIOUS 12 MONTHS.
PROTON PUMP INHIBITORS	LANSOPRAZOLE	PRIOR USE OF GENERIC PRESCRIPTION OMEPRAZOLE OR PANTOPRAZOLE WITHIN THE PREVIOUS 12 MONTHS.
RENIN INHIBITOR THERAPY	AMTURNIDE | EXFORGE | EXFORGE HCT | TEKAMLO | TEKTURNA | TEKTURNA HCT	PRIOR USE OF A FORMULARY ACE INHIBITOR (SUCH AS BENAZEPRIL, CAPTOPRIL, ENALAPRIL, LISINOPRIL, RAMIPRIL, BENAZEPRIL-HCTZ OR LISINOPRIL-HCTZ) OR OF A FORMULARY ARB (SUCH AS LOSARTAN, LOSARTAN HCTZ, DIOVAN, DIOVAN HCT, AVAPRO OR AVALIDE) WITHIN THE PREVIOUS 12 MONTHS.
SAVELLA	SAVELLA	PRIOR USE OF GABAPENTIN WITHIN THE PREVIOUS 12 MONTHS.
ULORIC	ULORIC	PRIOR USE OF ALLOPURINOL WITHIN THE PREVIOUS 12 MONTHS.

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VOLTAREN GEL	VOLTAREN	PRIOR USE OF ONE OTHER FORMULARY PRESCRIPTION NON-STEROIDAL ANTI-INFLAMMATORY MEDICATION (SUCH AS FLURBIPROFEN, IBUPROFEN, MELOXICAM, NAPROXEN, PIROXICAM, SULINDAC, TOLMETIN OR OTHER NSAIDS) WITHIN THE PREVIOUS 12 MONTHS.
ZOLPIDEM CR	ZOLPIDEM TARTRATE ER	PRIOR USE OF GENERIC ZOLPIDEM REGULAR RELEASE WITHIN THE PREVIOUS 12 MONTHS.