2017 Medicare Part D Step Therapy Requirements

Effective: November 01, 2017

Formulary ID 17191, Version 17
Last Updated: 10/24/2017

BISPHOSPHONATE THERAPY

Products Affected

- **FOSAMAX PLUS D 70 MG-2,800 UNIT TABLET**
- **FOSAMAX PLUS D 70 MG-5,600 UNIT TABLET**
- *risedronate 150 mg tablet*
- *risedronate 30 mg tablet*
- *risedronate 35 mg tablet*
- *risedronate 35 mg tablet (4 pack)*
- *risedronate 5 mg tablet*

Details

Criteria	PRIOR USE OF GENERIC ALENDRONATE WITHIN THE PREVIOUS 12 MONTHS.

INVOKANA

Products Affected

- **INVOKAMET 150 MG-1,000 MG TABLET**
- **INVOKAMET 150 MG-500 MG TABLET**
- **INVOKAMET 50 MG-1,000 MG TABLET**
- **INVOKAMET 50 MG-500 MG TABLET**
- **INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE**
- **INVOKANA 100 MG TABLET**
- **INVOKANA 300 MG TABLET**

Details

Criteria	PRIOR USE OF GENERIC METFORMIN, METFORMIN/GLIPIZIDE, METFORMIN/PIOGLITAZONE, OR JENTADUETO WITHIN THE PREVIOUS 12 MONTHS.

JARDIANCE

Products Affected

- **JARDIANCE 10 MG TABLET**
- **JARDIANCE 25 MG TABLET**
- **SYNJARDY 12.5 MG-1,000 MG TABLET**
- **SYNJARDY 12.5 MG-500 MG TABLET**
- **SYNJARDY 5 MG-1,000 MG TABLET**
- **SYNJARDY 5 MG-500 MG TABLET**
- **SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE**
- **SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE**

Details

Criteria	PRIOR USE OF GENERIC METFORMIN, METFORMIN/GLIPIZIDE, METFORMIN/PIOGLITAZONE, OR JENTADUETO WITHIN THE PREVIOUS 12 MONTHS.

LEVEMIR

Products Affected

- **LEVEMIR 100 UNIT/ML SUBCUTANEOUS SOLUTION**
- **LEVEMIR FLEXTOUCH 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN**

Details

Criteria	PRIOR USE OF LANTUS OR TOUJEO WITHIN THE PREVIOUS 12 MONTHS.

OMEGA-3-ACID ETHYL ESTERS

Products Affected

- *omega-3 acid ethyl esters 1 gram capsule*
- *triklo 1 gram capsule*

Details

Criteria	PRIOR USE OF GEMFIBROZIL OR A FORMULARY FENOFIBRATE WITHIN THE PREVIOUS 12 MONTHS.

RENIN INHIBITOR THERAPY

Products Affected

- *amlodipine 10 mg-valsartan 160 mg tablet*
- *amlodipine 10 mg-valsartan 160 mg-hydrochlorothiazide 12.5 mg tablet*
- *amlodipine 10 mg-valsartan 160 mg-hydrochlorothiazide 25 mg tablet*
- *amlodipine 10 mg-valsartan 320 mg tablet*
- *amlodipine 10 mg-valsartan 320 mg-hydrochlorothiazide 25 mg tablet*
- *amlodipine 5 mg-valsartan 160 mg tablet*
- *amlodipine 5 mg-valsartan 160 mg-hydrochlorothiazide 12.5 mg tablet*
- *amlodipine 5 mg-valsartan 160 mg-hydrochlorothiazide 25 mg tablet*
- *amlodipine 5 mg-valsartan 320 mg tablet*

Details

Criteria	PRIOR USE OF A FORMULARY ACE INHIBITOR (SUCH AS BENAZEPRIL, CAPTOPRIL, ENALAPRIL, LISINOPRIL, RAMIPRIL, BENAZEPRIL-HCTZ OR LISINOPRIL-HCTZ) OR OF A GENERIC FORMULARY ARB (SUCH AS LOSARTAN, LOSARTAN HCTZ, IRBESARTAN, IRBESARTAN-HCTZ) WITHIN THE PREVIOUS 12 MONTHS.

ULORIC

Products Affected

- **ULORIC 40 MG TABLET**
- **ULORIC 80 MG TABLET**

Details

Criteria	PRIOR USE OF ALLOPURINOL WITHIN THE PREVIOUS 12 MONTHS.

VASCEPA

Products Affected

- **VASCEPA 0.5 GRAM CAPSULE**
- **VASCEPA 1 GRAM CAPSULE**

Details

Criteria	PRIOR USE OF GEMFIBROZIL OR A FORMULARY FENOFIBRATE WITHIN THE PREVIOUS 12 MONTHS.

ZOLPIDEM CR

Products Affected

- *zolpidem er 12.5 mg tablet,extended release,multiphase*
- *zolpidem er 6.25 mg tablet,extended release,multiphase*

Details

Criteria	PRIOR USE OF GENERIC ZOLPIDEM REGULAR RELEASE WITHIN THE PREVIOUS 12 MONTHS.

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risedronate 35 mg tablet 1
risedronate 35 mg tablet (4 pack) 1
risedronate 5 mg tablet 1
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