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## **Drugs That Require Step Therapy (ST) Before Being Approved for Coverage**

In some cases, AvMed Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Step-1 and Step-2 drugs both treat your medical condition, we may not cover the Step-2 drug unless you try the Step-1 drug first. If the Step-1 drug does not work for you, we will then cover the Step-2 drug.

You will need authorization from AvMed Medicare before filling prescriptions for the Step-2 drugs shown in the chart that begins on the next page. AvMed Medicare will only provide coverage after it determines that the drug is being prescribed according to the criteria specified in the chart.

You, your appointed representative, or your prescriber can request prior authorization by calling AvMed at 1-800-782-8633, October 1 - March 31, 8:00 AM-8:00 PM, seven days a week, and April 1 - September 30, 8:00 AM - 8:00 PM Monday - Friday, 9:00 AM - 1:00 PM Saturday. Customer Service is available in English and other languages. TTY users should call 711.

## Step Therapy Criteria

**Step Therapy Group**

**Drug Names**

**Step Therapy Criteria**

BISPHOSPHONATES

FOSAMAX PLUS D

Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).

**Step Therapy Group**

**Drug Names**

**Step Therapy Criteria**

HMG-COA INHIBITORS

ALTOPREV, EZALLOR SPRINKLE, LIVALO, ZYPITAMAG

Coverage will be provided if atorvastatin, ezetimibe/simvastatin, fluvastatin, fluvastatin extended-release, lovastatin, pravastatin, rosuvastatin tablets, simvastatin tablets, or amlodipine/atorvastatin has been tried (at least a 30-day supply) in the prior 180 days.

**Step Therapy Group**

**Drug Names**

**Step Therapy Criteria**

PPI

ESOMEPRAZOLE MAGNESIUM, LANSOPRAZOLE ODT

Coverage will be provided if two of the following generic alternatives: omeprazole capsules, pantoprazole tablets, or lansoprazole capsules have been tried (at least a 30 day supply in the prior 180 days).

**Step Therapy Group**

**Drug Names**

**Step Therapy Criteria**

URINARY ANTISPASMODICS

DARIFENACIN HYDROBROMIDE, TOLTERODINE TARTRATE, TOLTERODINE TARTRATE ER

Coverage will be provided if fesoterodine, mirabegron, oxybutynin, oxybutynin extended-release, solifenacin tablets, or trospium immediate-release has been tried (at least a 30-day supply in the prior 180 days).