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Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans)

Table of Contents

Overview ..... 1
Coverage Policy..... 1
References ..... 7

Related Coverage Resources

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

Employer Group Plans have a Prescription Drug List that subjects certain brand name drugs to step therapy requiring medical necessity review.

Coverage Policy

Cigna approves coverage for these brand name drugs as medically necessary when there is a documented failure, inadequate response, contraindication per FDA label, or intolerance to the number of Step 1 and/or Step 2 drugs, or as otherwise specified in the table below.

Step Therapy (ST) definitions:

- Step 1 Medications – These medications do not require Step Therapy, are automatically covered, and do not require prior authorization.
• Step 2 Medications – Usually brand name medications. These medications do not require Step Therapy, are automatically covered, and do not require prior authorization.

- **Step 3 Medications** – Usually brand name medications. These medications require Step Therapy. If the physician determines the treatment plan should begin with a Step 3 medication, a request for authorization will need to be submitted and approved.

(Note: Not all plans will use all Step Therapy classes in the table below. Where noted, certain benefit plans may require different numbers of alternatives as prerequisite therapy.)

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Note: Receipt of sample product does not satisfy any criteria requirements for coverage.

### Cigna Employer Group Plans: Value and Advantage Prescription Drug Lists

<b>Antidepressants</b> Complete Plan: Requires THREE Step 1 agents unless specified below Essential Plan: Requires THREE Step 1 agents unless specified below Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>• bupropion (Wellbutrin/Wellbutrin SR/Wellbutrin XL)</li> <li>• citalopram (generic Celexa)</li> <li>• desvenlafaxine succ ER (generic Pristiq)</li> <li>• duloxetine (generic Cymbalta)</li> <li>• escitalopram (generic Lexapro)</li> <li>• fluoxetine (generic Prozac/Prozac Weekly/Sarafem)</li> <li>• fluvoxamine</li> <li>• paroxetine (generic Paxil/Paxil CR)</li> <li>• sertraline (generic Zoloft)</li> <li>• venlafaxine/venlafaxine er (generic Effexor/Effexor XR)</li> <li>• vilazodone (generic Viibryd)</li> </ul>		<ul style="list-style-type: none"> <li>• Fetzima</li> <li>• Sarafem</li> </ul>
An exception to the criteria will be provided when an individual is not a candidate for (e.g., stabilized condition where therapeutic interchange is inappropriate) the Step Therapy requirements.		
<b>Anti-Parkinsonism Drugs</b> Complete Plan: Requires ONE Step 1 agent Essential Plan: N/A Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>• selegiline</li> </ul>		<ul style="list-style-type: none"> <li>• Xadago</li> </ul>
<b>Attention Deficit Hyperactive Disorder (ADHD)</b> Complete Plan: N/A Essential Plan: Requires ONE Step 1 agent Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>• amphetamine sulfate (generic Evekeo)</li> </ul>		<ul style="list-style-type: none"> <li>• Adderall</li> <li>• Evekeo</li> <li>• Focalin</li> </ul>

<ul style="list-style-type: none"> <li>amphetamine/dextroamphetamine (generic Adderall)</li> <li>amphetamine/dextroamphetamine ER (generic Adderall XR)</li> <li>d-amphetamine (generic Dexedrine/Dextrostat)</li> <li>dexmethylphenidate (generic Focalin)</li> <li>dexmethylphenidate ER (generic Focalin XR)</li> <li>dextroamphetamine (generic Zenzedi)</li> <li>methamphetamine (generic Desoxyn)</li> <li>methylphenidate (generic Ritalin)</li> <li>methylphenidate CD/ER/LA/SA (generic Ritalin LA/Concerta)</li> </ul>		<ul style="list-style-type: none"> <li>Ritalin</li> <li>Zenzedi</li> </ul>
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An exception to the criteria will be provided when an individual is not a candidate for (e.g., stabilized condition where therapeutic interchange is inappropriate) the Step Therapy requirements.

**Atypical Antipsychotic Agents**  
**Complete Plan: Requires ONE Step 1 agent**  
**Essential Plan: Requires ONE Step 1 agent**  
**Limited Plan: N/A**

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>aripiprazole (generic Abilify)</li> <li>clozapine (generic Clozaril)</li> <li>clozapine ODT (generic Fazaclo)</li> <li>lurasidone (generic Latuda)</li> <li>olanzapine/olanzapine ODT (generic Zyprexa/Zyprexa Zydis)</li> <li>paliperidone (generic Invega)</li> <li>pimozide</li> <li>quetiapine (generic Seroquel)</li> <li>quetiapine ER (generic Seroquel XR)</li> <li>risperidone (generic Risperdal/Risperdal M)</li> <li>risperidone ODT</li> <li>ziprasidone (generic Geodon)</li> </ul>		<ul style="list-style-type: none"> <li>Caplyta</li> <li>Fanapt</li> <li>Invega</li> <li>Rexulti</li> <li>Risperdal/Risperdal M – <b>Effective until 6/30/2024</b></li> <li>Saphris</li> <li>Secuado Patch</li> <li>Seroquel</li> <li>Seroquel XR</li> <li>Vraylar</li> </ul>

An exception to the criteria will be provided when an individual is not a candidate for (e.g., stabilized condition where therapeutic interchange is inappropriate) the Step Therapy requirements.

\*An exception to the Step Therapy requirement criteria may be provided if individual has documented inability to take tablet formulations

**Diabetes Care**  
**Complete Plan: Requires ONE Step 1 agent**  
**Essential Plan: Requires ONE Step 1 agent**  
**Limited Plan: N/A**

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>metformin (greater than or equal to 1,500 mg per day)</li> </ul>		<ul style="list-style-type: none"> <li>Farxiga</li> <li>Glyxambi</li> <li>Janumet</li> <li>Janumet XR</li> <li>Januvia</li> <li>Jardiance</li> <li>Synjardy</li> <li>Synjardy XR</li> </ul>

		<ul style="list-style-type: none"> <li>• Trijardy XR</li> <li>• Xigduo XR</li> </ul>
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Note: The metformin step requirement criteria applies to new starts only.

An exception to Step Therapy criteria will be provided when BOTH of the following are met:

- Documented ONE of the following
  - Unable to achieve goal HbA1C despite of metformin or metformin-containing regimen (meglitides, sulfonylureas, or thiazolidinediones) at greater than or equal to 1,500 mg per day
  - Intolerance to metformin 1,500 mg per day despite appropriate dose titration duration (for example, period of 8-12 weeks)
  - Contraindication to metformin (for example, acute/chronic metabolic acidosis, severe renal dysfunction)
  - Individual is using agent for a non-diabetic FDA-approved indication
  - For Farxiga or Jardiance, the individual has heart failure with reduced ejection fraction
  - For Jardiance, the individual has heart failure with preserved ejection fraction
  - For Farxiga, the individual has chronic kidney disease
  - For Farxiga or Jardiance, the individual has atherosclerotic cardiovascular disease or, according to the prescriber, the patient has at least two risk factors for cardiovascular disease
  - Initial dual metformin combination therapy is clinically appropriate for elevated HbA1C (for example; greater than 1.5% above goal)
  - Initial dual metformin combination therapy is clinically appropriate in an individual with co-morbid conditions (such as ASCVD, heart failure, or CKD)
- Individual will continue maximally tolerated metformin therapy unless contraindicated, intolerant, or otherwise not a candidate

<b>Fibrates-Standard Dose</b> <b>Complete Plan: Requires THREE Step 1 agents</b> <b>Essential Plan: N/A</b> <b>Limited Plan: N/A</b>		
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Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>• fenofibrate: 120mg, 150mg, 160mg</li> <li>• fenofibrate micronized: 130mg, 134mg, 200mg</li> <li>• fenofibrate nanocrystallized: 145mg</li> <li>• fenofibric acid 105mg</li> <li>• fenofibric acid DR 135mg</li> </ul>		<ul style="list-style-type: none"> <li>• Fibracor 105 Mg Tablet</li> <li>• Lipofen 150 Mg Capsule</li> <li>• Tricor 145 Mg Tablet</li> <li>• Trilipix DR 135 Mg Capsule</li> <li>• Triglide</li> </ul>

<b>Fibrates-Low Dose</b> <b>Complete Plan: Requires THREE Step 1 agents</b> <b>Essential Plan: N/A</b> <b>Limited Plan: N/A</b>		
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Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>• fenofibrate : 40mg, 50mg, 54mg</li> <li>• fenofibrate micronized: 43mg, 67mg</li> <li>• fenofibrate nanocrystallized: 48mg</li> <li>• fenofibric acid 35mg</li> <li>• fenofibric acid DR 45mg</li> </ul>		<ul style="list-style-type: none"> <li>• Fibracor 35 Mg Tablet</li> <li>• Lipofen 50 Mg Capsule</li> <li>• Tricor 48 Mg Tablet</li> <li>• Trilipix DR 45 Mg Capsule</li> </ul>

<b>Hypnotics</b> <b>Complete Plan: Requires ONE Step 1 agent</b> <b>Essential Plan: Requires ONE Step 1 agent</b> <b>Limited Plan: N/A</b>		
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Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> <li>• doxepin (generic Silenor)</li> </ul>		<ul style="list-style-type: none"> <li>• Dayvigo</li> </ul>

<ul style="list-style-type: none"> <li>• eszopiclone (generic Lunesta)</li> <li>• ramelteon (generic Rozerem)</li> <li>• zaleplon (generic Sonata)</li> <li>• zolpidem (generic Ambien and Intermezzo)</li> <li>• zolpidem er (generic Ambien CR)</li> </ul>		<ul style="list-style-type: none"> <li>• Sonata</li> </ul>
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b> <b>Complete Plan: Requires TWO Step 1 agents</b> <b>Essential Plan: Requires TWO Step 1 agents</b> <b>Limited Plan: N/A</b>		
<b>Step 1 Medications</b>	<b>Step 2 Medications</b>	<b>Step 3 Medications</b>
<ul style="list-style-type: none"> <li>• celecoxib (generic Celebrex)</li> <li>• diclofenac (generic Voltaren/Voltaren-XR/Cataflam)</li> <li>• diclofenac/misoprostol (generic Arthrotec)</li> <li>• etodolac (generic Lodine/Lodine XL)</li> <li>• fenoprofen calcium 600mg</li> <li>• flurbiprofen (generic Ansaid)</li> <li>• ibuprofen (generic Motrin)</li> <li>• indomethacin (generic Indocin/Indocin SR)</li> <li>• ketoprofen (generic Oruvail) 50mg, 75mg</li> <li>• meclufenamate sodium</li> <li>• mefenamic acid</li> <li>• meloxicam (generic Mobic)</li> <li>• nabumetone</li> <li>• naproxen tablets (generic Naprosyn/EC-Naprosyn/Anaprox)</li> <li>• oxaprozin (generic Daypro)</li> <li>• piroxicam (generic Feldene)</li> <li>• sulindac (generic Clinoril)</li> <li>• tolmetin (generic Tolectin/Tolectin DS)</li> </ul>		<ul style="list-style-type: none"> <li>• Anaprox DS</li> <li>• Arthrotec 50</li> <li>• Arthrotec 75</li> <li>• Celebrex</li> <li>• Daypro</li> <li>• EC-Naprosyn</li> <li>• Feldene</li> <li>• Lodine</li> <li>• Mobic</li> <li>• Nalfon 600mg</li> <li>• Naprosyn tablets</li> <li>• Qmiiiz ODT</li> <li>• Voltaren</li> <li>• Voltaren XR</li> </ul>
<b>Non-Steroidal Topical</b> <b>Complete Plan: Requires ONE Step 1 agent</b> <b>Essential Plan: Requires ONE Step 1 agent</b> <b>Limited Plan: N/A</b>		
<b>Step 1 Medications</b>	<b>Step 2 Medications</b>	<b>Step 3 Medications</b>
<ul style="list-style-type: none"> <li>• pimecrolimus cream (generic for Elidel cream)</li> <li>• tacrolimus ointment (generic for Protopic)</li> <li>• prescription topical corticosteroid</li> </ul>		<ul style="list-style-type: none"> <li>• Eucrisa</li> </ul>
An exception to Step Therapy criteria will be provided when the following is met: <ul style="list-style-type: none"> <li>• Individual is less than 2 years of age</li> </ul>		
<b>Osteoporosis</b> <b>Complete Plan: Requires ONE Step 1 agent</b> <b>Essential Plan: Requires ONE Step 1 agent</b> <b>Limited Plan: N/A</b>		
<b>Step 1 Medications</b>	<b>Step 2 Medications</b>	<b>Step 3 Medications</b>

<ul style="list-style-type: none"> <li>alendronate (generic Fosamax)</li> <li>ibandronate (generic Boniva)</li> <li>risedronate (generic Actonel and Atelvia)</li> </ul>		<ul style="list-style-type: none"> <li>Actonel</li> <li>Atelvia</li> <li>Binosto</li> <li>Boniva</li> <li>Fosamax</li> <li>Fosamax Plus D</li> </ul>
<b>Respiratory</b>		
<b>Step 1 Medications</b>	<b>Step 2 Medications</b>	<b>Step 3 Medications</b>
<b>Inhaled Corticosteroid (ICS) with Long-Acting Beta Agonist (LABA)</b> <b>Complete Plan: Requires ONE Step 1</b> <b>Essential Plan: Requires ONE Step 1</b> <b>Limited Plan: N/A</b>		
<ul style="list-style-type: none"> <li>Wixela Inhub/fluticasone-salmeterol (Generic Advair Diskus)</li> </ul>		<ul style="list-style-type: none"> <li>AirDuo Digihaler</li> </ul>
<b>Topical Inflammatory</b>		
<b>Complete Plan: Requires THREE Step 1 agents</b> <b>Essential Plan: Requires THREE Step 1 agents</b> <b>Limited Plan: N/A</b>		
<b>Step 1 Medications</b>	<b>Step 2 Medications</b>	<b>Step 3 Medications</b>
<b>Topical Inflammatory, Very High Potency</b>		
<ul style="list-style-type: none"> <li>betamethasone dipropionate, augmented 0.05% gel, ointment, lotion</li> <li>clobetasol propionate 0.05% cream, foam, oint, gel, lotion, shampoo, soln, spray</li> <li>fluocinonide 0.1% cream</li> <li>halobetasol propionate 0.05% cream, ointment</li> </ul>		<ul style="list-style-type: none"> <li>Bryhali Lotion</li> <li>Clodan</li> <li>Diprolene</li> <li>Temovate</li> <li>Ultravate cream, ointment</li> </ul>
<b>Topical Inflammatory, High Potency</b>		
<ul style="list-style-type: none"> <li>amcinonide 0.1% cream, lotion, ointment</li> <li>betamethasone dipropionate 0.05% ointment</li> <li>betamethasone dipropionate, augmented 0.05% cream</li> <li>desoximetasone 0.05% gel, ointment</li> <li>desoximetasone 0.25% cream, ointment, spray</li> <li>fluocinonide 0.05% cream, gel, ointment, solution</li> <li>triamcinolone acetonide 0.5% cream, ointment</li> </ul>		<ul style="list-style-type: none"> <li>Topicort 0.05% Gel, Ointment</li> <li>Topicort 0.25% Cream, Ointment, Spray</li> </ul>
<b>Topical Inflammatory, Medium Potency</b>		
<ul style="list-style-type: none"> <li>betamethasone dipropionate 0.05% cream, lotion, spray</li> <li>betamethasone valerate 0.1% cream, foam</li> <li>clocortolone pivalate 0.1% cream</li> <li>desoximetasone 0.05% cream</li> </ul>		<ul style="list-style-type: none"> <li>Cloderm</li> <li>Luxiq</li> <li>Synalar</li> <li>Topicort 0.05% Cream</li> <li>Dermasorb TA</li> </ul>

<ul style="list-style-type: none"> <li>• fluocinolone acetonide 0.025% cream, ointment</li> <li>• fluocinonide 0.05% cream (emollient base)</li> <li>• fluticasone propionate 0.005% ointment, cream, lotion</li> <li>• hydrocortisone butyrate 0.1% cream, lotion, ointment, solution</li> <li>• hydrocortisone valerate 0.2% cream, ointment</li> <li>• mometasone furoate 0.1% cream, lotion, ointment</li> <li>• prednicarbate 0.1% cream, ointment</li> <li>• triamcinolone acetonide 0.025% cream, lotion, ointment</li> <li>• triamcinolone acetonide 0.1% cream, lotion, ointment</li> </ul>		<ul style="list-style-type: none"> <li>• Dermatop</li> <li>• Elocon</li> </ul>
<b>Topical Inflammatory, Low Potency</b>		
<ul style="list-style-type: none"> <li>• alclometasone dipropionate 0.05% cream and ointment</li> <li>• betamethasone valerate 0.1% lotion</li> <li>• desonide 0.05% cream, lotion, ointment, gel</li> <li>• fluocinolone acetonide 0.01% cream, oil, solution</li> <li>• hydrocortisone cream, lotion, ointment</li> </ul>		<ul style="list-style-type: none"> <li>• Ala-Scalp</li> <li>• Capex Shampoo</li> <li>• Derma-Smoothe-FS</li> <li>• Dermasorb HC</li> <li>• Desonate</li> <li>• Nucort</li> <li>• Scalacort DK</li> <li>• Synalar</li> <li>• Synalar TS</li> <li>• Texacort</li> </ul>

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6. U.S. Food and Drug Administration. Generic Drugs Questions and Answers: <http://www.fda.gov/Drugs/ResourcesForYou/Consumers/QuestionsAnswers/ucm100100.htm>

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