

## Step Therapy Criteria

<b>Step Therapy Group</b>	ARIPRAZOLE ODT
<b>Drug Names</b>	ARIPRAZOLE ODT
<b>Step Therapy Criteria</b>	Coverage will be provided if generic aripiprazole immediate release tablet has been tried (at least a 30-day supply in the prior 180 days).
<b>Step Therapy Group</b>	BARACLUDE SOL
<b>Drug Names</b>	BARACLUDE
<b>Step Therapy Criteria</b>	Coverage will be provided if generic entecavir tablets have been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	BISPHOSPHONATES
<b>Drug Names</b>	ALENDRONATE SODIUM, RISEDROATE SODIUM DR
<b>Step Therapy Criteria</b>	Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	LAMOTRIGINE
<b>Drug Names</b>	LAMOTRIGINE ER
<b>Step Therapy Criteria</b>	Coverage will be provided if generic lamotrigine immediate release tablets or generic lamotrigine chewable, dispersible tablet has been tried (at least a 30 day supply in the prior 180 days).
<b>Step Therapy Group</b>	LEVALBUTEROL
<b>Drug Names</b>	LEVALBUTEROL TARTRATE HFA
<b>Step Therapy Criteria</b>	Coverage will be provided if albuterol HFA or Ventolin HFA have been tried (at least a 30-day supply) in the prior 180 days.
<b>Step Therapy Group</b>	OLANZAPINE ODT
<b>Drug Names</b>	OLANZAPINE ODT
<b>Step Therapy Criteria</b>	Coverage will be provided if generic olanzapine immediate release tablet has been tried (at least a 30-day supply in the prior 180 days).
<b>Step Therapy Group</b>	PPI
<b>Drug Names</b>	ESOMEPRAZOLE MAGNESIUM
<b>Step Therapy Criteria</b>	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).
<b>Step Therapy Group</b>	RISPERIDONE ODT
<b>Drug Names</b>	RISPERIDONE ODT
<b>Step Therapy Criteria</b>	Coverage will be provided if generic risperidone immediate release tablet has been tried (at least a 30-day supply in the prior 180 days).

**Step Therapy Group**  
**Drug Names**  
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URINARY ANTISPASMODICS

TOLTERODINE TARTRATE ER

Coverage will be provided if one of the following generics has been tried (at least a 30-day supply in the prior 180 days): oxybutynin tablets, oxybutynin solution, oxybutynin extended-release tablets, solifenacin tablets, tolterodine immediate-release tablets, or trospium immediate-release tablets.