Effective Date 05/15/2025
Coverage Policy Number 1801

Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans)

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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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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:
Standard and Performance Prescription Drug Lists

Angiotensin Converting Enzyme Inhibitors/Angiotensin Receptor Blockers (ACE/ARB) **Complete Plan: Requires TWO Step 1 agents** **Essential Plan: Requires TWO Step 1 agents** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• benazepril (generic Lotensin) • benazepril/HCTZ (generic Lotensin HCT) • candesartan (generic Atacand) • candesartan/HCTZ (generic Atacand HCT) • captopril (generic Capoten) • captopril/HCTZ (generic Capozide) • enalapril (generic Vasotec) • enalapril/HCTZ (generic Vaseretic) • eprosartan (generic Teveten) • fosinopril (generic Monopril) • fosinopril HCTZ (generic Monopril HCT) • irbesartan (generic Avapro) • irbesartan/HCTZ (generic Avalide) • lisinopril (generic Prinivil/Zestril) • lisinopril/HCTZ (generic Zestoretic)		• Accupril • Accuretic • Avalide • Benicar – Effective until 6/30/2025 • Benicar HCT – Effective until 6/30/2025 • Diovan – Effective until 6/30/2025 • Diovan HCT – Effective until 6/30/2025 • Hyzaar • Lotensin • Lotensin HCT • Micardis • Micardis HCT • Prinivil • valsartan oral solution

• losartan (generic Cozaar) • losartan/HCTZ (generic Hyzaar) • moexipril • moexipril/HCTZ • olmesartan (generic Benicar) • olmesartan/HCTZ (generic Benicar HCT) • perindopril • quinapril (generic Accupril) • quinapril/HCTZ (generic Accuretic) • ramipril (generic Altace) • telmisartan (generic Micardis) • telmisartan/HCTZ (generic Micardis HCTZ) • trandolapril (generic Mavik) • valsartan (generic Diovan) tablets • valsartan/HCTZ (generic Diovan HCT)		• Vaseretic • Zestoretic
Antidepressants **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**
• bupropion (Wellbutrin/ Wellbutrin SR/Wellbutrin XL) • citalopram (generic Celexa) • desvenlafaxine succ ER (generic Pristiq) • duloxetine (generic Cymbalta) • escitalopram (generic Lexapro) • fluoxetine (generic Prozac/Prozac Weekly/Sarafem • fluvoxamine • paroxetine (generic Paxil/Paxil CR) • sertraline (generic Zoloft) • venlafaxine/venlafaxine ER (generic Effexor/Effexor XR) • vilazodone (generic Viibryd)		• Fetzima • Prozac Weekly • Sarafem
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.		
Anti-Parkinsonism Drugs (Monoamine Oxidase Type B (MAO-B) Inhibitors) **Complete Plan: Requires ONE Step 1 agent** **Essential Plan: N/A** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• selegiline		• Xadago
Anti-Parkinsonism Drugs (Carbidopa and Levodopa Products) **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**

• generic carbidopa-levodopa extended-release tablets		• Crexont capsules • Rytary capsules
An exception to Step Therapy criteria will be provided when the patient is currently taking Crexont capsules or Rytary capsules.		
Attention Deficit Hyperactive Disorder (ADHD) **Complete Plan: N/A** **Essential Plan: Requires FOUR Step 1 agents unless specified below** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• amphetamine sulfate (generic Evekeo) • amphetamine/dextroamphetamine (generic Adderall) • amphetamine/dextroamphetamine ER (generic Adderall XR) • d-amphetamine (generic Dexedrine/Dextrostat) • dexmethylphenidate (generic Focalin) • dexmethylphenidate ER (generic Focalin XR) • dextroamphetamine (generic Zenzedi) • lisdexamfetamine dimesylate capsules or chewable tablets (generic for Vyvanse) • methamphetamine (generic Desoxyn) • methylphenidate (generic Ritalin) • methylphenidate CD/ER/LA/SA (generic Ritalin LA/Concerta) • mixed salts of a single-entity amphetamine product extended-release capsules (generic for Mydayis)		• Adderall • Azstarys (Requires **ONE** Step 1 Medication) • Evekeo • Focalin • Ritalin • Zenzedi
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**
• aripiprazole (generic Abilify) • clozapine (generic Clozaril) • clozapine ODT (generic Fazaclo) • lurasidone (generic Latuda) • olanzapine/olanzapine ODT (generic Zyprexa/Zyprexa Zydis) • paliperidone (generic Invega) • pimozide • quetiapine (generic Seroquel) • quetiapine ER (generic Seroquel XR)		• Caplyta – Effective until 6/30/2025 • Invega • Rexulti – Effective until 6/30/2025 • Saphris • Secuado Patch • Seroquel • Seroquel XR

• risperidone (generic Risperdal/Risperdal M) • risperidone ODT • ziprasidone (generic Geodon)		• Vraylar – Effective until 6/30/2025
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.		
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**
• metformin		• Farxiga • Glyxambi • Janumet • Janumet XR • Januvia • Jardiance • Synjardy • Synjardy XR • Trijardy XR • Xigduo XR
Note: The metformin step requirement criteria applies to new starts only. An exception to Step Therapy criteria will be provided when ONE of the following are met: 1. The patient will be initiating dual therapy with metformin AND Farxiga or Jardiance, approve Farxiga or Jardiance. 2. The patient has a contraindication to metformin, according to the prescriber, approve Farxiga or Jardiance. Note: Examples of contraindications to metformin include acute or chronic metabolic acidosis, including diabetic ketoacidosis. 3. If the patient has heart failure with reduced ejection fraction, approve Farxiga or Jardiance. 4. If the patient has heart failure with preserved ejection fraction, approve Farxiga or Jardiance. 5. If the patient has chronic kidney disease, approve Farxiga or Jardiance. 6. If the patient has atherosclerotic cardiovascular disease or, according to the prescriber, the patient has at least two risk factors for cardiovascular disease, approve Farxiga or Jardiance.		
Fibrates-Standard Dose **Complete Plan: Requires THREE Step 1 agents** **Essential Plan: N/A** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• fenofibrate: 120mg, 150mg, 160mg • fenofibrate micronized: 130mg, 134mg, 200mg • fenofibrate nanocrystallized: 145mg • fenofibric acid 105mg • fenofibric acid DR 135mg		• Fibricor 105mg Tablet • Lipofen 150mg Capsule • Tricor 145mg Tablet • Trilipix DR 135mg Capsule • Triglide
Fibrates-Low Dose **Complete Plan: Requires THREE Step 1 agents** **Essential Plan: N/A**		

Limited Plan: N/A		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• fenofibrate: 40mg, 50mg, 54mg • fenofirbate micronized: 43mg, 67mg • fenofibrate nanocrystallized: 48mg • fenofibric acid 35mg • fenofibric acid DR 45mg		• Fibricor 35mg Tablet • Lipofen 50mg Capsule • Tricor 48mg Tablet • Trilipix DR 45mg Capsule
Hypnotics **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**
• doxepin (generic Silenor) • eszopiclone (generic Lunesta) • ramelteon (generic Rozerem) • zaleplon (generic Sonata) • zolpidem (generic Ambien and Intermezzo) • zolpidem ER (generic Ambien CR)		• Dayvigo • Sonata
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) **Complete Plan: Requires TWO Step 1 agents** **Essential Plan: Requires TWO Step 1 agents** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• celecoxib (generic Celebrex) • diclofenac (generic Voltaren XR) • diclofenac/misoprostol (generic Arthrotec) • etodolac/ER (generic Lodine, Lodine XL) • fenoprofen calcium 600 mg • flurbiprofen (generic Ansaid) • ibuprofen (generic Motrin) • indomethacin (generic Indocin/Indocin SR) • ketoprofen (generic Oruvail) 50mg, 75mg • meclofenamate sodium • mefenamic acid (generic Ponstel) • meloxicam (generic Mobic) • nabumetone • naproxen tablets (generic Naprosyn/EC-Naprosyn/Anaprox) • oxaprozin (generic Daypro) • piroxicam (generic Feldene) • sulindac • tolmetin		• Anaprox DS • Arthrotec 50 • Arthrotec 75 • Celebrex - Effective until 6/30/2025 • Daypro • EC-Naprosyn • Feldene • Lodine • Mobic • Nalfon 600mg • Naprosyn tablets • Qmiiz ODT • Voltaren XR

Non-Steroidal Topical 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**
• pimecrolimus cream (generic for Elidel cream) • tacrolimus ointment (generic for Protopic) • prescription topical corticosteroid		• Eucrisa • Zoryve 0.15% cream
An exception to Eucrisa Step Therapy criteria will be provided when the following is met: • The patient is < 2 years of age		

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Ophthalmic Corticosteroids Complete Plan: Requires TWO Step 1 agents Essential Plan: Requires TWO Step 1 agents Limited Plan: N/A		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• dexamethasone sodium phosphate ophthalmic solution 0.1% • difluprednate ophthalmic emulsion 0.05% • fluorometholone ophthalmic suspension 0.1% • loteprednol ophthalmic gel 0.5% • loteprednol etabonate ophthalmic suspension 0.5% • prednisolone acetate ophthalmic suspension 1% • prednisolone sodium ophthalmic solution 1%		• Inveltys 1% ophthalmic suspension • Lotemax 0.5% ophthalmic ointment • Lotemax SM 0.38% ophthalmic gel
An exception to Step Therapy criteria for Lotemax ophthalmic ointment will be provided when the following is met: 1. The patient has an allergy to benzalkonium chloride		

Osteoporosis 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**
• alendronate (generic Fosamax) • ibandronate (generic Boniva) • risedronate (generic Actonel and Atelvia)		• Actonel • Atelvia • Binosto • Boniva • Fosamax • Fosamax Plus D

Proton Pump Inhibitors (PPI) **Complete Plan: Requires TWO Step 1 agents** **Essential Plan: Requires TWO Step 1 agents** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• dexlansoprazole (generic for Dexilant) • esomepreazole (generic Nexium) • esomeprazole strontium • lansoprazole (generic Prevacid) • omeprazole (generic Prilosec) • pantoprazole (generic Protonix) • rabeprazole (generic Aciphex)		• Prevacid Caps • Protonix
Respiratory		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
Inhaled Corticosteroid (ICS) with Long-Acting Beta Agonist (LABA) **Complete Plan: Requires ONE Step 1** **Essential Plan: Requires ONE Step 1** **Limited Plan: N/A**		
• Wixela Inhub/fluticasone-salmeterol (Generic Advair Diskus)		• AirDuo Digihaler
Statins **Complete Plan: Requires TWO Step 1 agents unless specified below** **Essential Plan: Requires TWO Step 1 agents unless specified below** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
• atorvastatin (generic Lipitor) • ezetimibe-simvastatin (generic Vytorin) • fluvastatin/fluvastatin ER (generic Lescol/Lescol XL) • lovastatin • pitavastatin (generic for Livalo) • pravastatin (generic Pravachol) • rosuvastatin calcium (generic Crestor) • simvastatin (generic Zocor)		• Altoprev • Lescol • Vytorin – Effective until 6/30/2025
Topical Inflammatory **Complete Plan: Requires THREE Step 1 agents** **Essential Plan: Requires THREE Step 1 agents** **Limited Plan: N/A**		
Step 1 Medications	**Step 2 Medications**	**Step 3 Medications**
Topical Inflammatory, Very High Potency		
• betamethasone dipropionate, augmented 0.05% gel, ointment, lotion • clobetasol propionate 0.05% cream, foam, ointment, gel, lotion, shampoo, solution, spray • fluocinonide 0.1% cream		• Bryhali 0.01% Lotion • Clodan 0.05% Kit • Diprolene 0.05% Ointment • Temovate 0.05% Cream, Ointment • Ultravate 0.05% Cream, Ointment

• halobetasol propionate 0.05% cream, ointment		
Topical Inflammatory, High Potency		
• amcinonide 0.1% cream, lotion, ointment • betamethasone dipropionate 0.05% ointment • betamethasone dipropionate, augmented 0.05% cream • desoximetasone 0.05% gel, ointment • desoximetasone 0.25% cream, ointment, spray • fluocinonide 0.05% cream, gel, ointment, solution • triamcinolone acetonide 0.5% cream, ointment		• Topicort 0.05% Gel, Ointment • Topicort 0.25% Cream, Ointment, Spray
Topical Inflammatory, Medium Potency		
• betamethasone dipropionate 0.05% cream, lotion, spray • betamethasone valerate 0.1% cream, foam • clocortolone pivalate 0.1% cream • desoximetasone 0.05% cream • fluocinolone acetonide 0.025% cream, ointment • fluocinonide 0.05% cream (emollient base) • fluticasone propioinate 0.005% ointment, cream, lotion • hydrocortisone butyrate 0.1% cream, ointment, solution • hydrocortisone valerate 0.2% cream, ointment • mometasone furoate 0.1% cream, lotion, ointment • prednicarbate 0.1% cream, ointment • triamcinolone acetonide 0.025% cream, lotion, ointment • triamcinolone acetonide 0.1% cream, lotion, ointment		• Cloderm 0.1% Cream, Cream Pump • Dermasorb TA • Dermatop • Elocon • Luxiq 0.12% Foam • Sylanar 0.025% Cream, Cream Kit, Ointment, Ointment Kit • Topicort 0.05% Cream
Topical Inflammatory, Low Potency		
• alclometasone dipropionate 0.05% cream and ointment • betamethasone valerate 0.1% lotion • desonide 0.05% cream, lotion, ointment, gel • fluocinolone acetonide 0.01% cream, oil, solution • hydrocortisone cream, lotion, ointment		• Ala-scalp 2% Lotion • Capex Shampoo • Derma-Smoothe-FS Body Oil, Scalp Oil • Dermasorb HC • Desonate 0.05% Gel • Nucort Lotion • Scalacort DK 2% Kit • Synalar 0.01% Solution • Synalar TS 0.01% Kit

		• Texacort 2.5% Solution

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Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	**Removed** Aciphex, Altace, Avapro, Cozaar, Fanapt, and Zestril from the policy, effective 1/1/2025.	11/15/2024
Selected Revision	**Clarified** the current Anti-Parkinsonism Drugs step therapy requirements apply to Monoamine Oxidase Type B (MAO-B) Inhibitors. **Added** new step therapy requirements for the following Carbidopa and Levodopa Products, Crexont and Rytary.	01/15/2025
Selected Revision	**Removed** Benicar, Benicar HCT, Caplyta, Celebrex, Diovan, Diovan HCT, Rexulti, Vraylar, and Vytorin from the policy, effective 7/1/2025. **Added** a new Ophthalmic Corticosteroids section, with Inveltys 1% ophthalmic suspension, Lotemax 0.5% ophthalmic ointment, and Lotemax SM 0.28% ophthalmic gel added as Step 3 Medications, effective 7/1/2025. **Added** Zoryve 0.15% cream, as a Step 3 Medication, to the Non-Steroidal Topical section.	05/15/2025