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Coverage Policy Number 1802

Step Therapy – Value and Advantage 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: Value and Advantage Prescription Drug Lists

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
<ul style="list-style-type: none"> • 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) 		<ul style="list-style-type: none"> • Fetzima • 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
<ul style="list-style-type: none"> • selegiline 		<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> generic carbidopa-levodopa extended-release tablets 		<ul style="list-style-type: none"> 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 Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> 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) 		<ul style="list-style-type: none"> Adderall 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
<ul style="list-style-type: none"> aripiprazole (generic Abilify) clozapine (generic Clozaril) clozapine ODT (generic Fazaclo) lurasidone (generic Latuda) 		<ul style="list-style-type: none"> Caplyta Invega Rexulti Saphris

<ul style="list-style-type: none"> • olanzapine/olanzapine ODT (generic Zyprexa/Zyprexa Zydis) • paliperidone (generic Invega) • pimozide • quetiapine (generic Seroquel) • quetiapine ER (generic Seroquel XR) • risperidone (generic Risperdal/Risperdal M) • risperidone ODT • ziprasidone (generic Geodon) 		<ul style="list-style-type: none"> • Secuado Patch • Seroquel • Seroquel XR • Vraylar
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"> • metformin 		<ul style="list-style-type: none"> • Farxiga • Glyxambi • Janumet • Janumet XR • Januvia • Jardiance • Synjardy • Synjardy XR • Trijardy XR • Xigduo XR
<p>Note: The metformin step requirement criteria applies to new starts only.</p> <p>An exception to Step Therapy criteria will be provided when ONE of the following are met:</p> <ol style="list-style-type: none"> 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
<ul style="list-style-type: none"> fenofibrate: 120mg, 150mg, 160mg fenofibrate micronized: 130mg, 134mg, 200mg fenofibrate nanocrystallized: 145mg fenofibric acid 105mg fenofibric acid DR 135mg 		<ul style="list-style-type: none"> Fibricor 105 Mg Tablet Lipofen 150 Mg Capsule Tricor 145 Mg Tablet Trilipix DR 135 Mg 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
<ul style="list-style-type: none"> fenofibrate : 40mg, 50mg, 54mg fenofibrate micronized: 43mg, 67mg fenofibrate nanocrystallized: 48mg fenofibric acid 35mg fenofibric acid DR 45mg 		<ul style="list-style-type: none"> Fibricor 35 Mg Tablet Lipofen 50 Mg Capsule Tricor 48 Mg Tablet Trilipix DR 45 Mg 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
<ul style="list-style-type: none"> doxepin (generic Silenor) eszopiclone (generic Lunesta) ramelteon (generic Rozerem) zaleplon (generic Sonata) zolpidem (generic Ambien and Intermezzo) zolpidem er (generic Ambien CR) 		<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> celecoxib (generic Celebrex) diclofenac (generic Voltaren/Voltaren-XR/Cataflam) diclofenac/misoprostol (generic Arthrotec) etodolac (generic Lodine/Lodine XL) fenoprofen calcium 600mg flurbiprofen (generic Ansaid) ibuprofen (generic Motrin) indomethacin (generic Indocin/Indocin SR) ketoprofen (generic Oruvail) 50mg, 75mg 		<ul style="list-style-type: none"> Anaprox DS Arthrotec 50 Arthrotec 75 Celebrex - Effective until 6/30/2025 Daypro EC-Naprosyn Feldene Lodine Mobic Nalfon 600mg Naprosyn tablets Qmiiz ODT

<ul style="list-style-type: none"> meclofenamate sodium mefenamic acid meloxicam (generic Mobic) nabumetone naproxen tablets (generic Naprosyn/EC-Naprosyn/Anaprox) oxaprozin (generic Daypro) piroxicam (generic Feldene) sulindac (generic Clinoril) tolmetin (generic Tolectin/Tolectin DS) 		<ul style="list-style-type: none"> Voltaren 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
<ul style="list-style-type: none"> pimecrolimus cream (generic for Elidel cream) tacrolimus ointment (generic for Protopic) prescription topical corticosteroid 		<ul style="list-style-type: none"> Eucrisa Zoryve 0.15% cream
An exception to Eucrisa Step Therapy criteria will be provided when the following is met: <ul style="list-style-type: none"> The patient is < 2 years of age 		
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
<ul style="list-style-type: none"> alendronate (generic Fosamax) ibandronate (generic Boniva) risedronate (generic Actonel and Atelvia) 		<ul style="list-style-type: none"> Actonel Atelvia Binosto Boniva Fosamax Fosamax Plus D
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		
<ul style="list-style-type: none"> Wixela Inhub/fluticasone-salmeterol (Generic Advair Diskus) 		<ul style="list-style-type: none"> AirDuo Digihaler
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		
<ul style="list-style-type: none"> betamethasone dipropionate, augmented 0.05% gel, ointment, lotion clobetasol propionate 0.05% cream, foam, oint, gel, lotion, shampoo, soln, spray fluocinonide 0.1% cream halobetasol propionate 0.05% cream, ointment 		<ul style="list-style-type: none"> Bryhali Lotion Clodan Diprolene Temovate Ultravate cream, ointment
Topical Inflammatory, High Potency		
<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> Topicort 0.05% Gel, Ointment Topicort 0.25% Cream, Ointment, Spray
Topical Inflammatory, Medium Potency		
<ul style="list-style-type: none"> 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 propionate 0.005% ointment, cream, lotion hydrocortisone butyrate 0.1% cream, lotion, 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 		<ul style="list-style-type: none"> Cloderm Luxiq Synalar Topicort 0.05% Cream Dermasorb TA Dermatop Elocon
Topical Inflammatory, Low Potency		

<ul style="list-style-type: none"> • 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 		<ul style="list-style-type: none"> • Ala-Scalp • Capex Shampoo • Derma-Smoothe-FS • Dermasorb HC • Desonate • Nucort • Scalacort DK • Synalar • Synalar TS • Texacort
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2. Drug Facts and Comparisons. Facts & Comparisons® eAnswers [online]. Available from Wolters Kluwer Health, Inc.
3. U.S. Food and Drug Administration. Drugs@FDA. U.S. Department of Health & Human Services: <http://www.accessdata.fda.gov/scripts/cder/drugsatfda/>
4. U.S. Food and Drug Administration. Drugs@FDA. U.S. Department of Health & Human Services: Vyvanse https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021977s045,208510s001lbl.pdf
5. U.S. Food and Drug Administration. FDA List of Authorized Generic Drugs: How Drugs are Developed and Approved: <http://www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/approvalapplications/abbreviatednewdrugapplicationandagenerics/ucm126389.htm>
6. U.S. Food and Drug Administration. Generic Drugs Questions and Answers: <http://www.fda.gov/Drugs/ResourcesForYou/Consumers/QuestionsAnswers/ucm100100.htm>

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	Removed Fanapt, Jentadueto, Jentadueto XR, and Tradjenta, 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 Celebrex from the policy, effective 7/1/2025. Added Zoryve 0.15% cream, as a Step 3 Medication, to the Non-Steroidal Topical section.	05/15/2025

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