



Effective Date 5/1/2024
Coverage Policy Number 1802

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**

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 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
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) 		<ul style="list-style-type: none"> • Adderall • Evekeo • Focalin • Ritalin

<ul style="list-style-type: none"> 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"> 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) 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"> Caplyta Fanapt Invega Rexulti Risperdal/Risperdal M – Effective until 6/30/2024 Saphris 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

		<ul style="list-style-type: none"> • Jardiance • Jentadueto • Jentadueto XR • Synjardy • Synjardy XR • Tradjenta • 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
<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"> • Fibracor 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"> • Fibracor 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) 		<ul style="list-style-type: none"> • Dayvigo • Sonata

<ul style="list-style-type: none"> • zaleplon (generic Sonata) • zolpidem (generic Ambien and Intermezzo) • zolpidem er (generic Ambien CR) 		
--	--	--

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 • 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"> • Anaprox DS • Arthrotec 50 • Arthrotec 75 • Celebrex • Daypro • EC-Naprosyn • Feldene • Lodine • Mobic • Nalfon 600mg • Naprosyn tablets • Qmiiz ODT • 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

An exception to Step Therapy criteria will be provided when the following is met:

- Individual is less than 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

- Wixela Inhub/fluticasone-salmeterol (Generic Advair Diskus)

- 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

- 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

- Bryhali Lotion
- Clodan
- Diprolene
- Temovate
- Ultravate 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 propionate 0.005% ointment, cream, lotion
- hydrocortisone butyrate 0.1% cream, lotion, ointment, solution
- hydrocortisone valerate 0.2% cream, ointment

- Cloderm
- Luxiq
- Synalar
- Topicort 0.05% Cream
- Dermasorb TA
- Dermatop
- Elocon

<ul style="list-style-type: none"> • 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 		
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

References

1. McEvoy GK, ed. AHFS 2017 Drug Information. Bethesda, MD: American Society of Health-Systems Pharmacists, Inc. Available from Stat!Ref, Teton Data Systems, Inc.
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>

“Cigna Companies” refers to operating subsidiaries of Cigna Corporation. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. © 2024 Cigna.