Pharmacy Drug Policy

SUBJECT: Step Therapy
POLICY NUMBER: PHARMACY-72
EFFECTIVE DATE: 10/2011
LAST REVIEW DATE: 11/12/2026

If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:

Policy Application

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☐ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☐ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☐ Dual Eligible Special Needs Plan (D-SNP)	

DESCRIPTION:

Step Therapy encourages use of safe, cost-effective medications within different therapeutic drug categories. The entry of new generics and cost-effective therapeutic alternatives has provided an opportunity to promote these therapies as first-line.

POLICY:

Step Therapy requires members to try certain first-line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brands and generics. Typically, first-line medications are classified as generics, but there are instances where brand name medications may be preferred.

Based upon our review and assessment of the peer-reviewed literature, these medications have been medically proven to be effective and therefore **medically necessary** for medical treatment if the request meets the following criteria:

ANTIBACTERIALS	
Drug	**Requirement**
Doryx, Doryx MPC	Coverage requires documentation of serious side effects or drug failure with immediate-release doxycycline **AND** immediate-release minocycline
Doxycycline hyclate DR	
Clindagel 75 mL	Coverage requires documentation of serious side effects or drug failure with generic clindamycin **AND** tretinoin
Clindamycin 1% Gel 75 mL (Oceanside & Solaris)	
Amzeeq	Coverage requires serious side effects or drug failure with TWO topical treatments for acne (erythromycin, clindamycin, tretinoin, adapalene, dapsone, tazarotene)
Zilxi 1.5%	Coverage requires serious side effects or drug failure with topical metronidazole and one additional topical antibiotic (such as clindamycin, erythromycin, azelaic acid).

ANTICOAGULANTS	
Drug	**Requirement**
Savaysa	Coverage requires documentation of serious side effects or drug failure with Xarelto (rivaroxaban) or Eliquis

ANTIDEPRESSANTS	
Drug	**Requirement**
Emsam	Coverage requires documentation of serious side effects or drug failure with at least **ONE** of the following first line agents: escitalopram, fluoxetine, citalopram, sertraline, paroxetine, mirtazapine, bupropion or venlafaxine **immediate-release** tablets or venlafaxine extended-release **capsules**
Forfivo XL 450 mg	
Venlafaxine ER **Tablets**	Coverage requires documentation of serious side effects or drug failure with venlafaxine ER capsules, **<u>however</u>:** • Equal doses of venlafaxine HCL extended-release tablets are bioequivalent to venlafaxine ER capsules, but are not substitutable at the pharmacy level • A daily dose of 225 mg venlafaxine ER may be obtained by ordering venlafaxine ER 75 mg capsules, taken as 3 capsules once daily • A daily dose of 112.5 mg venlafaxine ER may be obtained by ordering venlafaxine ER 37.5 mg capsules, taken as 3 capsules once daily • The claims processing system will not read history for this edit therefore claims will not automatically pay, therefore a manual step therapy request must be made for coverage determination
Drizalma Sprinkle	Coverage requires serious side effects or drug failure with duloxetine

ANTIEMETICS	
Drug	**Requirement**
Sancuso	Coverage requires documentation of serious side effects or drug failure with ondansetron **AND** granisetron

ANTIFUNGAL AGENTS	
Drug	**Requirement**
Ecoza	Coverage requires documentation of serious side effects or drug failure with TWO of the following generic topical antifungals: ciclopirox, econazole, ketoconazole, nystatin
Econazole nitrate 1% foam	
Ertaczo	
Luzu	
Luliconazole	
Naftin	
Naftifine	
Xolegel	
Oxistat Lotion	

ANTIMIGRAINE AGENTS	
Drug	**Requirement**
Onzetra Spray	Coverage requires documentation of serious side effects or drug failure with TWO generic triptans:(Almotriptan, Eletriptan, Frovatriptan, Naratriptan, Rizatriptan, Sumatriptan, Zolmitriptan)
Zomig Nasal Spray/Zolmitriptan Nasal Spray	

Tosymra	Coverage requires documentation of serious side effects or drug failure with generic sumatriptan nasal spray **AND** ONE generic oral triptan: (Almotriptan, Eletriptan, Frovatriptan, Naratriptan, Rizatriptan, Sumatriptan, Zolmitriptan)
Zembrace	Coverage requires documentation of serious side effects or drug failure with injectable sumatriptan

ANTIPSYCHOTICS

Drug	Diagnosis	Requirement
Caplyta	Schizophrenia	Coverage requires documentation of serious side effects or drug failure with TWO generic atypical antipsychotics
	Bipolar Depression	Coverage requires documentation of serious side effects or drug failure with TWO alternative therapies for bipolar depression
	Major Depressive Disorder	Coverage requires documentation of serious side effects or drug failure with TWO different antidepressants (with different mechanisms of action) used in combination OR ONE antidepressant in combination with ONE other augmentation therapy (such as atypical antipsychotic, lithium, buspirone)
Fanapt	Schizophrenia	Coverage requires documentation of serious side effects or drug failure with TWO generic atypical antipsychotics
	Bipolar Disorder	
Rexulti	Schizophrenia	Coverage requires documentation of serious side effects or drug failure with TWO generic atypical antipsychotics
	Major Depressive Disorder	Coverage requires documentation of serious side effects or drug failure with TWO different antidepressants (with different mechanisms of action) used in combination **OR** ONE antidepressant in combination with ONE other augmentation therapy (such as atypical antipsychotic, lithium, buspirone)
	Agitation associated with Dementia due to Alzheimer disease	Requests for this diagnosis will be approved.
Secuado	Schizophrenia	Coverage requires documentation of serious side effects or drug failure with TWO generic atypical antipsychotics
Vraylar	Schizophrenia	Coverage requires documentation of serious side effects or drug failure with TWO generic atypical antipsychotics
	Bipolar disorder	
	Bipolar Depression	Coverage requires documentation of serious side effects or drug failure with TWO alternative therapies for bipolar depression
	Major Depressive Disorder	Coverage requires documentation of serious side effects or drug failure with TWO different antidepressants (with different mechanisms of action) used in combination **OR** ONE antidepressant in combination with ONE other augmentation therapy (such as atypical antipsychotic, lithium, buspirone)

ANTIVIRALS

Drug	Requirement
Acyclovir 5% cream	Coverage requires documentation of serious side effects or drug failure with acyclovir 5% ointment.
Penciclovir 1% cream	
Xerese 5%-1% cream	
Zovirax 5% cream	Coverage requires documentation of serious side effects or drug failure with acyclovir 5% ointment **AND** generic acyclovir 5% cream

Denavir 1% cream	Coverage requires documentation of serious side effects or drug failure with acyclovir 5% ointment **AND** generic penciclovir 1% cream

BLOOD GLUCOSE REGULATORS
(SELECT BENEFITS ONLY)

Drug	Requirement
Admelog Apidra Fiasp Kirsty, Kirsty pen Novolog, Novolog Mix 70/30, Insulin Aspart Lyumjev	Coverage requires documentation of serious side effects or drug failure with Humalog, Humalog Mix 75/25, or Insulin Lispro (Lilly unbranded version)
Novolin 70-30, Novolin N, Novolin R	Coverage requires documentation of serious side effects or drug failure with corresponding Humulin product (N, R, 70-30)
Tresiba, Insulin degludec, Awiqli	Coverage requires documentation of serious side effects or drug failure with ONE of the following: Lantus, insulin glargine, insulin glargine-yfgn, Toujeo
Nesina Alogliptin Kazano Alogliptin/metformin Oseni Alogliptin/pioglitazone	Coverage requires documentation of serious side effects or drug failure with Tradjenta or Jentadueto
Glumetza Fortamet Metformin ER (generics of Fortamet and Glumetza), Metformin HCl 625 mg	Coverage requires documentation of serious side effects or drug failure with generic immediate-release metformin **AND** generic extended-release metformin (generic equivalent of Glucophage XR)
Blood Glucose Meters and Test Strips	<u>For patients aligned to 2025 formularies</u>: Coverage of any non-preferred blood glucose meter or test strip requires either: a previous trial and failure **OR** the inability to use any Abbott (Freestyle or Precision Xtra) or One Touch products <u>For patients aligned to 2026 formularies</u>: Coverage of any non-preferred blood glucose meter or test strip requires either: a previous trial and failure **OR** the inability to use any Abbott (Freestyle or Precision Xtra) or Contour products
Dapagliflozin/Saxagliptin	Coverage requires documentation of serious side effects **OR** drug failure with Glyxambi
Invokamet, Invokamet XR, Segluromet	<u>For patients aligned to 2025 formularies</u>: Coverage requires documentation of serious side effects or drug failure with dapagliflozin/metformin ER **AND** Synjardy/Synjardy XR <u>For patients aligned to 2026 formularies</u>: Coverage requires documentation of serious side effects or drug failure with dapagliflozin/metformin ER

Synjardy, Syndardy XR	Coverage requires documentation of serious side effects or drug failure with dapagliflozin/metformin ER
Invokana, Steglatro	For patients aligned to 2025 formularies: Coverage requires documentation of serious side effects or drug failure with dapagliflozin **AND** Jardiance For patients aligned to 2026 formularies: Coverage requires documentation of serious side effects or drug failure with dapagliflozin
Jardiance	Coverage requires documentation of serious side effects or drug failure with dapagliflozin
Januvia (sitagliptin), Janumet and Janumet XR (sitagliptin and metformin)	Coverage requires documentation of serious side effects or drug failure with Tradjenta, Jentadueto, or Jentadueto XR **AND** generic sitagliptin (with or without metformin)
Sitagliptin (generic for Januvia), sitagliptin and metformin (generic for Janumet and Janumet XR)	Coverage requires documentation of serious side effects or drug failure with Tradjenta, Jentadueto, or Jentadueto XR
Steglujan (ertugliflozin/sitagliptin)	Coverage requires documentation of serious side effects or drug failure with Glyxambi

CARDIOVASCULAR AGENTS

Drug	Requirement
Edarbyclor	Coverage requires documentation of serious side effects or drug failure with TWO of the following: losartan/hctz, irbesartan/hctz, valsartan/hctz
Thalitone	Coverage requires documentation of serious side effects or drug failure with generic chlorthalidone.

CARDIOVASCULAR AGENTS, DYSLIPIDEMICS

Drug	Requirement
Livalo	Documentation of serious side effects or drug failure with TWO of the following generic statins: atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin
Pitavastatin Calcium	
Zypitamag	
Lipfendra	Coverage requires documentation of serious side effects or drug failure with Repatha.
Praluent	Coverage requires documentation of serious side effects or drug failure with Repatha for those aged 10 years and older.
Nexletol, Nexlizet	Coverage requires documentation of serious side effects or drug failure with one generic statin: atorvastatin, fluvastatin, lovastatin, pitavastatin, pravastatin, rosuvastatin, simvastatin

NEUROLOGICAL AGENTS

Drug	Requirement
Savella	Coverage requires documentation of serious side effects or drug failure with duloxetine and milnacipran

DERMATOLOGICAL AGENTS	
Drug	**Requirement**
Aczone 7.5%, Dapsone 7.5%	Coverage requires documentation of serious side effects or drug failure with a topical retinoid **AND** Dapsone 5%
Adapalene 0.1% Lotion, Soln, Swab	Coverage requires documentation of serious side effects or drug failure with adapalene cream or gel **AND** tretinoin cream or gel
Differin 0.1% Lotion	
Eucrisa Ointment	Coverage requires documentation of serious side effects or drug failure with ONE generic topical steroid (aclometasone, amcinonide, betamethasone, clobetasol, desonide, desoximetasone, diflorasone, fluocinolone, fluocinonide–E, fluticasone, halobetasol, hydrocortisone 2.5%, hydrocortisone valerate, mometasone, prednicarbate, triamcinolone) **OR** ONE of the following: tacrolimus ointment or pimecrolimus cream.
Noritate	Coverage requires documentation of serious side effects or drug failure with generic metronidazole cream, gel, or lotion
Zyclara 2.5% Cream Pump, Zyclara 3.75% Cream and Zyclara 3.75% Cream Pump	Coverage requires documentation of serious side effects or drug failure with imiquimod 5% cream
Imiquimod 3.75% Cream, and Imiquimod 3.75% Cream Pump	

GASTROINTESTINAL AGENTS		
Drug		**Requirement**
Amitiza	Chronic idiopathic constipation or IBS-C	For patients aligned to 2025 formularies: Coverage requires documentation of serious side effects or drug failure with lubiprostone **AND** either Linzess **OR** Trulance for a diagnosis of chronic idiopathic constipation or irritable bowel syndrome with constipation. For patients aligned to 2026 formularies: Coverage requires documentation of serious side effects or drug failure with lubiprostone **AND** Trulance for a diagnosis of chronic idiopathic constipation or irritable bowel syndrome with constipation.
	Opioid-induced constipation	Coverage requires documentation of drug failure or serious side effects with lubiprostone **AND** Movantik for a diagnosis of opioid induced constipation.
Motegrity		For patients aligned to 2025 formularies: Coverage requires documentation of serious side effects or drug failure with prucalopride **AND** Linzess **OR** Trulance for a diagnosis of chronic idiopathic constipation (CIC) For patients aligned to 2026 formularies: Coverage requires documentation of serious side effects or drug failure with prucalopride **AND** Trulance for a diagnosis of chronic idiopathic constipation (CIC)

Linzess	Chronic idiopathic constipation	Coverage requires documentation of serious side effects or drug failure with **TWO** of the following: lubiprostone, prucalopride, Trulance
	IBS-C	Coverage requires documentation of serious side effects or drug failure with **TWO** of the following: lubiprostone, Trulance
	Functional constipation in pediatric patients 2-17 years of age	Requests for this diagnosis will be approved
Relistor Tablet		Coverage requires documentation of serious side effects or drug failure with lubiprostone **AND** Movantik for a diagnosis of opioid-induced constipation
Symproic		
Ibsrela		For patients aligned to 2025 formularies: Coverage requires documentation of serious side effects or drug failure with TWO of the following: prucalopride, lubiprostone, Linzess**,** Trulance for a diagnosis of irritable bowel syndrome with constipation For patients aligned to 2026 formularies: Coverage requires documentation of serious side effects or drug failure with TWO of the following: lubiprostone, Trulance for a diagnosis of irritable bowel syndrome with constipation
Omeprazole/Sodium Bicarbonate Packets		Coverage requires documentation of serious side effects or drug failure with TWO of the following: omeprazole, pantoprazole, lansoprazole, rabeprazole
Zegerid Packets		
Pheburane		Coverage requires documentation of serious side effects or drug failure with generic sodium phenylbutyrate

GENITOURINARY AGENTS

Drug	Requirement
Oxytrol	Coverage requires documentation of serious side effects or drug failure with TWO of the following: oxybutynin, oxybutynin ER, tolterodine, trospium, trospium XR **Exception:** Gelnique does not require step therapy for individuals 65 years of age or older
Gelnique	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)

Drug	Requirement
Bryhali	Coverage requires documentation of a serious side effects or drug failure with TWO of the following generic topical steroids: aclometasone, amcinonide, betamethasone, clobetasol, desonide, desoximetasone, diflorasone, fluocinolone, fluocinonide–E, fluticasone, halobetasol (except 0.05% foam and 0.05% lotion), hydrocortisone 2.5%, hydrocortisone
Cloderm, Clocortolone Pivalate	
Cordran (Cream, Lotion, Ointment)	
Desonide 0.05% Gel	
Halog, Halcinonide	
Halobetasol Propionate 0.05% Foam and 0.05% lotion	
Impeklo	

Impoyz Cream (and generic clobetasol 0.025% cream)	valerate, hydrocortisone butyrate (except lotion), mometasone, prednicarbate, triamcinolone
Lexette	
Pandel	
Sernivo Lotion	
Ultravate Lotion	
Verdeso	

IMMUNOLOGICAL AGENTS

Drug	Requirement
Prograf Granules	Must have documentation of serious side effects or drug failure with generic tacrolimus capsules **Exception:** age less than 9 years old

MULTIPLE SCLEROSIS AGENTS

Drug	Requirement
Ponvory	Coverage requires documentation of serious side effects or drug failure with **TWO** of the following agents: Avonex, Copaxone 40mg, glatiramer, Glatopa, fingolimod, dimethyl fumarate, Mayzent, Plegridy, Rebif, teriflunomide, Kesimpta, or Zeposia.
Vumerity	Coverage requires documentation of a trial of dimethyl fumarate (generic Tecfidera) that resulted in gastrointestinal (GI) intolerance **AND** a trial of **ONE** preferred agent (Avonex, Copaxone 40mg, glatiramer, Glatopa, fingolimod, Mayzent, Plegridy, Rebif, teriflunomide, Kesimpta, or Zeposia)

OPHTHALMIC AGENTS

Drug		Requirement
Zerviate		Coverage requires documentation of serious side effects or drug failure with TWO of the following antihistamine eye drops: azelastine, olopatadine, epinastine
Xelpros	Vyzulta	Coverage requires documentation of serious side effects or drug failure with Lumigan **AND** either latanoprost or travoprost
Zioptan		
Iyuzeh		
Tafluprost		
Zolymbus		
Rhopressa, Rocklatan		Coverage requires documentation of serious side effects or drug failure with any covered prostaglandin analogue (such as bimatoprost, travoprost, latanoprost, Lumigan)
Restasis 0.05%		Coverage requires documentation of serious side effects or drug failure of cyclosporine 0.05% eye emulsion **AND** Xiidra 5% eye drops
Restasis Multidose 0.05%		
Atropine Sulfate/PF		Coverage requires documentation of serious side effects or drug failure of generic atropine 1% drops

PANCREATIC ENZYMES

Drug	Requirement
Pancreaze	Coverage requires documentation of serious side effects or drug failure with Creon and Zenpep
Pertzye	

RESPIRATORY TRACT/PULMONARY AGENTS

Drug	Requirement
Tudorza Pressair	Coverage requires documentation of serious side effects or drug failure with ONE of the following: tiotropium bromide or Incruse.

Alvesco Pulmicort Flexhaler Armonair Digihaler	Coverage requires documentation of serious side effects or drug failure with ONE of the following: Arnuity Ellipta, Asmanex, or Qvar Redihaler.
Lonhala Magnair 25 mcg Starter Lonhala Magnair 25 mcg Refill Yupelri	Coverage requires documentation of serious side effects or drug failure with any TWO of the following long-acting muscarinic receptor antagonists (LAMA) containing inhalers: Anoro Ellipta, Bevespi Aerosphere, Incruse Ellipta, Neohaler, tiotropium bromide Handihaler, Spiriva Respimat, Stiolto Respimat, or Utibron
Duaklir Pressair	Coverage requires serious side effects or drug failure with at least TWO long-acting muscarinic receptor antagonist/long-acting beta agonist (LAMA/LABA) agents. Agents include: Anoro, Bevespi, Stiolto and Utibron.

SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS

Drug	Requirement
Estring Osphena	Coverage requires documentation of serious side effects or drug failure with a topical vaginal estrogen product such as Premarin cream or estradiol vaginal cream.

SKELETAL MUSCLE RELAXANTS

Drug	Requirement
Norgesic Forte Orphengesic Forte Orphenadrine/ Aspirin/Caffeine	Coverage requires documentation of serious side effects or drug failure with TWO of the following (generic) agents: baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, methocarbamol, metaxalone, orphenadrine, tizanidine

SLEEP DISORDER AGENTS

Drug	Requirement
Edluar	Coverage requires documentation of serious side effects or drug failure with zolpidem
Belsomra, Dayvigo, Quviviq	Coverage requires documentation of serious side effects or drug failure with TWO of the following: zolpidem, eszopiclone, zaleplon

POLICY GUIDELINES:

1. Initial approval will be granted for a period of 1 year.
   a. Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition.
2. This policy is applicable to drugs that are included on a specific drug formulary. If a drug referenced in this policy is non-formulary, please reference the Non-Formulary Medication Exception Review Policy for review guidelines.
3. Approval for step therapy requirements may not bypass MAC penalty. Please see MAC penalty policy for detail of this benefit.
4. Utilization Management is contract dependent. Refer to specific contract/benefit language for exclusions.
   a. Coverage criteria may be dependent on the contract renewal date.
   b. Coverage of drugs listed in this policy are contract dependent.
   c. Not all contracts/benefits allow coverage of healthcare professional administered drugs as part of their pharmacy benefit.
   d. Not all contracts/benefits cover all medical infusible drugs.
   e. Not all policy criteria may apply if treatment of specific disease states or conditions is not a covered benefit.

5. Clinical documentation must be submitted for each request (initial and recertification [if applicable]) unless otherwise specified (e.g., provider attestation required). Supporting documentation includes, but is not limited to, progress notes documenting previous treatments and treatment history, diagnostic testing, laboratory test results, genetic testing or biomarker results, imaging and other objective or subjective measures of benefit. For recertification, continued approval requires documentation demonstrating that the requested product is providing ongoing benefit to the patient, evidenced by improvement or stability in disease state or condition, and that continued use remains medically necessary. Ongoing use of the requested product must continue to align with the current policy's preferred formulary. Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline supported treatment options). Requested dosing must remain consistent with FDA-approved or off-label/guideline-supported dosing recommendations.
6. All requests will be reviewed to ensure they are being used for an appropriate indication and may be subject to an off-label review in accordance with our Off-Label Use of FDA Approved Drugs Policy (Pharmacy-32)
7. Dose and frequency should be in accordance with the FDA label or recognized compendia (for off-label uses). When services are performed in excess of established parameters, they may be subject to review for medical necessity.
8. All utilization management requirements outlined in this policy are compliant with applicable New York State insurance laws and regulations. Policies will be reviewed and updated as necessary to ensure ongoing compliance with all state and federally mandated coverage requirements.
9. For commercial contracts, medical necessity determinations align with the Certificate of Coverage issued by the Health Plan, which states that covered services must be clinically appropriate and not primarily for the convenience of the member, the member’s family, or the provider.
10. This policy is based on available evidence as of the last review date. Coverage determinations are subject to applicable plan documents, state and federal regulations, and individual patient circumstances. This policy does not constitute medical advice.
11. This policy is subject to ongoing revision. Newly marketed drugs and existing drugs with new indications may be subject to prior authorization until formal coverage criteria are established. Inclusion of a drug in this policy does not guarantee its current availability on the market, as some agents may be discontinued, withdrawn, or otherwise unavailable. As product status changes, drugs may be removed from the policy.
12. For Fully Insured Commercial and Exchange products only: New York State insurance requirements prohibit negative mid-plan-year formulary changes. Therefore, members enrolled in non-calendar-year plans (e.g., July-July renewals) may continue to follow the prior plan year’s formulary tier structure and corresponding utilization-management criteria until their group’s renewal date.
    a. Pharmacy Benefit Formulary ID Alignment
        i. 2025 Commercial/Exchange Formulary IDs: 5181,5899,2981
        ii. 2026 Commercial/Exchange/Essential Plan/Child Health Plus Formulary IDs: 2950,6262,3295,6264,6060,2977,5930
13. Approval timeframes may be extended to align authorization periods for drugs administered as part of a multidrug regimen, including when regimen components are administered across different benefits. This provision does not apply when the approval timeframe reflects a drug-specific limitation on duration of therapy.

UPDATES:

Date	Revision
11/12/2026	Reviewed / P&T Committee Approval
09/14/2026	Revised
08/25/2026	Revised
08/07/2026	Revised
08/04/2026	Revised
07/29/2026	Revised
06/04/2026	Revised
06/03/2026	Revised
05/08/2026	Revised
05/07/2026	Revised
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10/09/2025	Revised
09/08/2025	Revised
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03/06/2025	Revised
01/01/2025	Revised
11/21/2024	P&T Committee Review / Approval
10/21/2024	Revised
09/23/2024	Revised
09/13/2024	Revised
08/13/2024	Revised
05/10/2024	Revised
04/09/2024	Revised
03/14/2024	Revised
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9/7/2023	Revised
8/10/2023	Revised
7/7/2023	Revised
6/8/2023	Revised
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4/5/2023	Revised
3/31/2023	Revised
3/16/2023	Revised
2/9/2023	Revised
2/3/2023	Revised
12/20/2022	Revised
12/15/2022	Revised

12/2/22	Revised
11/17/2022	P&T Committee Approval
11/3/22	Revised
10/3/22	Revised
8/29/22	Revised
8/25/22	Revised
7/28/22	Revised
6/30/22	Revised
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5/1/2022	Revised
3/29/22	Revised
3/18/22	Revised
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1/22	Revised
12/21	Revised
11/21	Revised
10/21	Revised
9/21	Revised
8/21	Revised
5/21	Revised
4/21	Revised
3/21	Revised
2/11/2021	P&T Committee Approval
1/21	Revised
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10/20	Revised
8/2020	Revised
7/2020	Revised
6/2020	Revised
5/2020	Revised
3/20	Revised
2/20	Revised
1/20	Revised
12/19	Revised
11/19	Revised
10/19	Revised
8/19	Revised
7/19	Revised
5/19	P&T Committee Approval
4/19	Revised
3/19	Revised
2/19	Revised
1/19	Revised
11/18	Revised

10/18	Revised
9/18	Revised
5/18	Revised
4/18	Revised
3/18	Revised
2/18	Revised
1/18	Revised- Both STEP Policies combined to one policy The Commercial Open step therapy and Exchange Closed/CHP policies have been merged. The policy has also been changed into a table format with headers that match the web formularies (derived from RxFlex).
12/17	Revised
11/2017	P&T Committee Approval
9/17	Revised
7/17	Revised
5/17	Revised
4/17	Revised
1/17	Revised
10/16	Revised
9/16	Revised
8/16	Revised
7/16	Revised
6/16	Revised
5/16	Revised
4/16	Revised
3/16	Revised
1/16	Revised
12/15	Revised
11/15	Revised
8/15	Revised
7/15	Revised
6/15	Revised
5/15	Revised
4/15	Revised
3/15	Revised
1/15	Revised
11/14	Revised
10/14	Revised
8/14	Revised
7/14	Revised
5/14	Revised
3/14	Revised
1/14	Created