

Tribute 2017 Formulary 2017 Step Therapy Criteria

ARISTADA

Products Affected:

- Aristada Prefilled Syringe 1064 MG/3.9ML Intramuscular
- Aristada Prefilled Syringe 441 MG/1.6ML Intramuscular
- Aristada Prefilled Syringe 662 MG/2.4ML Intramuscular
- Aristada Prefilled Syringe 882 MG/3.2ML Intramuscular

Details

Criteria
Claim will pay automatically for ARISTADA if enrollee has a paid claim for at least a 1 days supply of ABILIFY MAINTENA in the past 365 days. Otherwise, ARISTADA requires a step therapy exception request indicating: (1) history of inadequate treatment response with ABILIFY MAINTENA OR (2) history of adverse event with ABILIFY MAINTENA OR (3) ABILIFY MAINTENA is contraindicated.

**Tribute 2017 Formulary
2017 Step Therapy Criteria**

AUBAGIO

Products Affected:

- Aubagio TABLET 14 MG ORAL
- Aubagio TABLET 7 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Aubagio IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Gilenya or Tecfidera IN THE PAST 365 DAYS. OTHERWISE, Aubagio REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Gilenya or Tecfidera, OR (2) HISTORY OF ADVERSE EVENT WITH Gilenya or Tecfidera, OR (3) Gilenya or Tecfidera IS CONTRAINDICATED.
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**Tribute 2017 Formulary
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DIFICID

Products Affected:

- Dificid TABLET 200 MG ORAL

Details

Criteria	Claim will pay automatically for Dificid if enrollee has a paid claim for at least a 1 days supply of vancomycin in the past 120 days. Otherwise, Dificid requires a step therapy exception request indicating: (1) history of inadequate treatment response with Vancomycin, OR (2) history of adverse event with Vancomycin, OR (3) Vancomycin is contraindicated.
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**Tribute 2017 Formulary
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PRADAXA

Products Affected:

- Pradaxa CAPSULE 110 MG Oral
- Pradaxa CAPSULE 150 MG ORAL

Details

Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Pradaxa IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Xarelto or Eliquis IN THE PAST 365 DAYS. OTHERWISE, Pradaxa REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Xarelto or Eliquis, OR (2) HISTORY OF ADVERSE EVENT WITH Xarelto or Eliquis, OR (3) Xarelto or Eliquis IS CONTRAINDICATED.
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Tribute 2017 Formulary
2017 Step Therapy Criteria
RHEUMATOID ARTHRITIS

Products Affected:

- Actemra SOLUTION 200 MG/10ML Intravenous
- Actemra SOLUTION 400 MG/20ML Intravenous
- Actemra SOLUTION 80 MG/4ML Intravenous
- Actemra Solution Prefilled Syringe 162 MG/0.9ML Subcutaneous
- Cimzia KIT 2 X 200 MG Subcutaneous
- Cimzia Prefilled KIT 2 X 200 MG/ML Subcutaneous
- Cosentyx Sensoready Pen Solution Auto-injector 150 MG/ML Subcutaneous
- Cosentyx Solution Prefilled Syringe 150 MG/ML Subcutaneous
- Kineret Solution Prefilled Syringe 100 MG/0.67ML Subcutaneous
- Orenzia ClickJect Solution Auto-injector 125 MG/ML Subcutaneous
- Orenzia Solution Prefilled Syringe 125 MG/ML Subcutaneous
- Orenzia Solution Prefilled Syringe 50 MG/0.4ML Subcutaneous
- Orenzia Solution Prefilled Syringe 87.5 MG/0.7ML Subcutaneous
- Orenzia SOLUTION RECONSTITUTED 250 MG Intravenous
- Otezla TABLET 30 MG ORAL
- Otezla Tablet Therapy Pack 10 & 20 & 30 MG Oral
- Simponi Aria SOLUTION 50 MG/4ML Intravenous
- Simponi Solution Auto-injector 100 MG/ML Subcutaneous
- Simponi Solution Auto-injector 50 MG/0.5ML Subcutaneous
- Simponi Solution Prefilled Syringe 50 MG/0.5ML Subcutaneous
- Stelara SOLUTION 130 MG/26ML Intravenous
- Stelara Solution Prefilled Syringe 45 MG/0.5ML Subcutaneous
- Xeljanz TABLET 5 MG ORAL

Details

Criteria	Claim will pay automatically for Actemra, Cimzia, Cosentyx, Kineret, Orenzia, Otezla, Simponi, Stelara, or Xeljanz if enrollee has a paid claim for at least a 1 days supply of Enbrel and Humira in the past 120 days. Otherwise, Actemra, Cimzia, Cosentyx, Kineret, Orenzia, Otezla, Simponi, Stelara, or Xeljanz requires a step therapy exception request indicating: (1) history of inadequate treatment response with Enbrel and Humira, OR (2) history of adverse event with Enbrel and Humira, OR (3) Enbrel and Humira is contraindicated. For diagnosis cryopyrin-associated periodic syndromes, Kineret will be approved. For diagnosis of Crohn's disease or Ulcerative Colitis, only Humira needs trial/failure.
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**Tribute 2017 Formulary
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TRINTELLIX

Products Affected:

- Trintellix TABLET 10 MG ORAL
- Trintellix TABLET 20 MG ORAL
- Trintellix TABLET 5 MG ORAL

Details

Criteria

Claim will pay automatically for trintellix if enrollee has a paid claim for at least a 1 days supply of any 2 generic formulary antidepressants in the past 365 days. Otherwise, trintellix requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 2 generic formulary antidepressants, OR (2) history of adverse event with any 2 generic formulary antidepressants, OR (3) any 2 generic formulary antidepressants are contraindicated.

Tribute 2017 Formulary 2017 Step Therapy Criteria

UCERIS

Products Affected:

- Uceris FOAM 2 MG/ACT Rectal
- Uceris Tablet Extended Release 24 Hour 9 MG Oral

Details

Criteria
Claim will pay automatically for Uceris if enrollee has a paid claim for at least a 1 days supply of any formulary corticosteroid used to treat ulcerative colitis in the past 365 days. Otherwise, Uceris requires a step therapy exception request indicating: (1) history of inadequate treatment response with formulary corticosteroid used to treat ulcerative colitis, OR (2) history of adverse event with formulary corticosteroid used to treat ulcerative colitis, OR (3) formulary corticosteroid used to treat ulcerative colitis is contraindicated.

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VEMLIDY

Products Affected:

- Vemlidy TABLET 25 MG ORAL

Details

Criteria	Claim will pay automatically for Vemlidy if enrollee has a paid claim for at least a 1 days supply of lamivudine in the past 365 days. Otherwise, Vemlidy requires a step therapy exception request indicating: (1) history of inadequate treatment response with lamivudine, OR (2) history of adverse event with lamivudine, OR (3) lamivudine is contraindicated.
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**Tribute 2017 Formulary
2017 Step Therapy Criteria**

VRAYLAR

Products Affected:

- Vraylar CAPSULE 1.5 MG Oral
- Vraylar CAPSULE 3 MG Oral
- Vraylar CAPSULE 4.5 MG Oral
- Vraylar CAPSULE 6 MG Oral
- Vraylar Capsule Therapy Pack 1.5 & 3 MG Oral

Details

Criteria	
	Claim will pay automatically for VRAYLAR if enrollee has a paid claim for at least a 1 days supply of ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, QUETIAPINE XR, ZIPRASIDONE or LATUDA in the past 365 days. Otherwise, Vraylar requires a step therapy exception request indicating any ONE of criteria 1, 2, 3, or 4: (1) history of inadequate treatment response with ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, QUETIAPINE XR, ZIPRASIDONE, or LATUDA or (2) history of adverse event with ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, QUETIAPINE XR, ZIPRASIDONE, or LATUDA or (3) ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, QUETIAPINE XR, ZIPRASIDONE or LATUDA are contraindicated or (4) For diagnosis of MANIC EPISODES ASSOCIATED WITH BIPOLAR DISORDER, THE COVERAGE DETERMINATION WILL BE APPROVED WITHOUT REQUIREMENT OF TRIAL AND FAILURE OR CONTRAINDICATION TO LATUDA.

**Tribute 2017 Formulary
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XTANDI

Products Affected:

- Xtandi CAPSULE 40 MG ORAL

Details

Criteria	Claim will pay automatically for Xtandi if enrollee has a paid claim for at least a 1 days supply of Zytiga in the past 365 days. Otherwise, Xtandi requires a step therapy exception request indicating: (1) history of inadequate treatment response with Zytiga, OR (2) history of adverse event with Zytiga, OR (3) Zytiga is contraindicated.
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Tribute 2017 Formulary

2017 Step Therapy Criteria

Alphabetical Listing

A

Actemra SOLUTION 200 MG/10ML	
Intravenous.....	5
Actemra SOLUTION 400 MG/20ML	
Intravenous.....	5
Actemra SOLUTION 80 MG/4ML	
Intravenous.....	5
Actemra Solution Prefilled Syringe 162	
MG/0.9ML Subcutaneous.....	5
Aristada Prefilled Syringe 1064 MG/3.9ML	
Intramuscular	1
Aristada Prefilled Syringe 441 MG/1.6ML	
Intramuscular	1
Aristada Prefilled Syringe 662 MG/2.4ML	
Intramuscular	1
Aristada Prefilled Syringe 882 MG/3.2ML	
Intramuscular	1
Aubagio TABLET 14 MG ORAL	2
Aubagio TABLET 7 MG ORAL	2

C

Cimzia KIT 2 X 200 MG Subcutaneous.....	5
Cimzia Prefilled KIT 2 X 200 MG/ML	
Subcutaneous	5
Cosentyx Sensoready Pen Solution Auto-	
injector 150 MG/ML Subcutaneous.....	5
Cosentyx Solution Prefilled Syringe 150	
MG/ML Subcutaneous.....	5

D

Dificid TABLET 200 MG ORAL.....	3
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K

Kineret Solution Prefilled Syringe 100	
MG/0.67ML Subcutaneous.....	5

O

Orencia ClickJect Solution Auto-injector	
125 MG/ML Subcutaneous.....	5
Orencia Solution Prefilled Syringe 125	
MG/ML Subcutaneous.....	5
Orencia Solution Prefilled Syringe 50	
MG/0.4ML Subcutaneous.....	5
Orencia Solution Prefilled Syringe 87.5	
MG/0.7ML Subcutaneous.....	5

Orencia SOLUTION RECONSTITUTED	
250 MG Intravenous	5
Otezla TABLET 30 MG ORAL	5
Otezla Tablet Therapy Pack 10 & 20 & 30	
MG Oral	5

P

Pradaxa CAPSULE 110 MG Oral	4
Pradaxa CAPSULE 150 MG ORAL.....	4

S

Simponi Aria SOLUTION 50 MG/4ML	
Intravenous.....	5
Simponi Solution Auto-injector 100	
MG/ML Subcutaneous.....	5
Simponi Solution Auto-injector 50	
MG/0.5ML Subcutaneous.....	5
Simponi Solution Prefilled Syringe 50	
MG/0.5ML Subcutaneous.....	5
Stelara SOLUTION 130 MG/26ML	
Intravenous.....	5
Stelara Solution Prefilled Syringe 45	
MG/0.5ML Subcutaneous.....	5

T

Trintellix TABLET 10 MG ORAL.....	6
Trintellix TABLET 20 MG ORAL.....	6
Trintellix TABLET 5 MG ORAL.....	6

U

Uceris FOAM 2 MG/ACT Rectal.....	7
Uceris Tablet Extended Release 24 Hour 9	
MG Oral	7

V

Vemlidy TABLET 25 MG ORAL.....	8
Vraylar CAPSULE 1.5 MG Oral	9
Vraylar CAPSULE 3 MG Oral	9
Vraylar CAPSULE 4.5 MG Oral	9
Vraylar CAPSULE 6 MG Oral	9
Vraylar Capsule Therapy Pack 1.5 & 3 MG	
Oral	9

X

Xeljanz TABLET 5 MG ORAL	5
Xtandi CAPSULE 40 MG ORAL.....	10

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