

**Provider Partners Health Plan of Ohio
2020 Formulary – Step Therapy Criteria**

ATYPICALS

Products Affected

Step 2:

- ABILIFY MAINTENA PREFILLED SYRINGE 300 MG INTRAMUSCULAR
- ABILIFY MAINTENA PREFILLED SYRINGE 400 MG INTRAMUSCULAR
- ABILIFY MAINTENA SUSPENSION RECONSTITUTED ER 300 MG INTRAMUSCULAR
- ABILIFY MAINTENA SUSPENSION RECONSTITUTED ER 400 MG INTRAMUSCULAR
- ABILIFY MYCITE TABLET 10 MG ORAL
- ABILIFY MYCITE TABLET 15 MG ORAL
- ABILIFY MYCITE TABLET 2 MG ORAL
- ABILIFY MYCITE TABLET 20 MG ORAL
- ABILIFY MYCITE TABLET 30 MG ORAL
- ABILIFY MYCITE TABLET 5 MG ORAL
- CAPLYTA CAPSULE 42 MG ORAL
- FANAPT TABLET 1 MG ORAL
- FANAPT TABLET 10 MG ORAL
- FANAPT TABLET 12 MG ORAL
- FANAPT TABLET 2 MG ORAL
- FANAPT TABLET 4 MG ORAL
- FANAPT TABLET 6 MG ORAL
- FANAPT TABLET 8 MG ORAL
- FANAPT TITRATION PACK TABLET 1 & 2 & 4 & 6 MG ORAL
- INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML INTRAMUSCULAR
- INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 156 MG/ML INTRAMUSCULAR
- INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML INTRAMUSCULAR
- INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML INTRAMUSCULAR
- INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML INTRAMUSCULAR
- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML INTRAMUSCULAR
- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 410 MG/1.315ML INTRAMUSCULAR
- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML INTRAMUSCULAR
- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 819 MG/2.625ML INTRAMUSCULAR
- LATUDA TABLET 120 MG ORAL
- LATUDA TABLET 20 MG ORAL
- LATUDA TABLET 40 MG ORAL
- LATUDA TABLET 60 MG ORAL
- LATUDA TABLET 80 MG ORAL
- NUPLAZID CAPSULE 34 MG ORAL
- NUPLAZID TABLET 10 MG ORAL
- PERSERIS PREFILLED SYRINGE 120 MG SUBCUTANEOUS
- PERSERIS PREFILLED SYRINGE 90 MG SUBCUTANEOUS
- REXULTI TABLET 0.25 MG ORAL
- REXULTI TABLET 0.5 MG ORAL
- REXULTI TABLET 1 MG ORAL
- REXULTI TABLET 2 MG ORAL
- REXULTI TABLET 3 MG ORAL
- REXULTI TABLET 4 MG ORAL

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- RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 12.5 MG INTRAMUSCULAR
- RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 25 MG INTRAMUSCULAR
- RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 37.5 MG INTRAMUSCULAR
- RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 50 MG INTRAMUSCULAR
- SAPHRIS TABLET SUBLINGUAL 10 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 2.5 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 5 MG SUBLINGUAL
- SECUADO PATCH 24 HOUR 3.8 MG/24HR TRANSDERMAL
- SECUADO PATCH 24 HOUR 5.7 MG/24HR TRANSDERMAL
- SECUADO PATCH 24 HOUR 7.6 MG/24HR TRANSDERMAL
- VERSACLOZ SUSPENSION 50 MG/ML ORAL
- 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
- ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 210 MG INTRAMUSCULAR

Details

| | |
|-----------------|--|
| Criteria | Claim will pay automatically for any brand formulary atypical antipsychotic if enrollee has a paid claim for at least a 1 day supply of any generic formulary atypical antipsychotic in the past 365 days. Otherwise, any brand formulary atypical antipsychotic requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary atypical antipsychotic, (2) history of adverse event with any generic formulary atypical antipsychotic, or (3) any generic formulary atypical antipsychotic is contraindicated. |
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CONDYLOX

Products Affected

Step 2:

- CONDYLOX GEL 0.5 % EXTERNAL

Details

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

**Provider Partners Health Plan of Ohio
2020 Formulary – Step Therapy Criteria**

DHE

Products Affected

Step 2:

- *dihydroergotamine mesylate solution 4 mg/ml nasal*

Details

| Criteria | |
|-----------------|--|
| | Claim will pay automatically for DHE if enrollee has a paid claim for at least a 1 day supply of any generic formulary serotonin (5-HT) 1b/1d receptor agonist (i.e. triptan) in the past 365 days. Otherwise, DHE requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary triptan, OR (2) history of adverse event with any generic formulary triptan, OR (3) any generic formulary triptan is contraindicated. |

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DIFICID

Products Affected

Step 2:

- DIFICID TABLET 200 MG ORAL

Details

| | |
|-----------------|---|
| Criteria | Claim will pay automatically for Dificid if enrollee has a paid claim for at least a 1 day supply of vancomycin or Firvanq in the past 120 days. Otherwise, Dificid requires a step therapy exception request indicating: (1) history of inadequate treatment response with vancomycin or Firvanq, OR (2) history of adverse event with vancomycin or Firvanq, OR (3) vancomycin or Firvanq is contraindicated. |
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**Provider Partners Health Plan of Ohio
2020 Formulary – Step Therapy Criteria**

NEUPRO

Products Affected

Step 2:

- NEUPRO PATCH 24 HOUR 1 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 2 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 3 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 4 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 6 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 8 MG/24HR TRANSDERMAL

Details

| | |
|-----------------|---|
| Criteria | Claim will pay automatically for Neupro if enrollee has a paid claim for at least a 1 day supply of pramipexole or ropinirole in the past 365 days. Otherwise, Neupro requires a step therapy exception request indicating: (1) history of inadequate treatment response with pramipexole or ropinirole, OR (2) history of adverse event with pramipexole or ropinirole, OR (3) pramipexole or ropinirole is contraindicated. |
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Provider Partners Health Plan of Ohio 2020 Formulary – Step Therapy Criteria

PPI

Products Affected

Step 2:

- DEXILANT CAPSULE DELAYED
RELEASE 30 MG ORAL
- DEXILANT CAPSULE DELAYED
RELEASE 60 MG ORAL

Details

| Criteria | Claim will pay automatically for Dexilant if enrollee has a paid claim for at least a 1 day supply of lansoprazole, omeprazole or pantoprazole in the past 365 days. Otherwise, Dexilant requires a step therapy exception request indicating: (1) history of inadequate treatment response with lansoprazole, omeprazole or pantoprazole, OR (2) history of adverse event with lansoprazole, omeprazole or pantoprazole, OR (3) lansoprazole, omeprazole or pantoprazole is contraindicated. |
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**Provider Partners Health Plan of Ohio
2020 Formulary – Step Therapy Criteria**

RYTARY

Products Affected

Step 2:

- RYTARY CAPSULE EXTENDED RELEASE 23.75-95 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 36.25-145 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 48.75-195 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 61.25-245 MG ORAL

Details

| Criteria | |
|-----------------|--|
| | Claim will pay automatically for Rytary if enrollee has a paid claim for at least a 1 day supply of any generic carbidopa, carbidopa/levodopa, or carbidopa/levodopa/entacapone in the past 365 days. Otherwise, Rytary requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic carbidopa, carbidopa/levodopa, or carbidopa/levodopa/entacapone OR (2) history of adverse event with any generic carbidopa, carbidopa/levodopa, or carbidopa/levodopa/entacapone, OR (3) any generic carbidopa, carbidopa/levodopa, or carbidopa/levodopa/entacapone is contraindicated. |

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**Provider Partners Health Plan of Ohio
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TOPICAL ANTI-INFLAMMATORY

Products Affected

Step 2:

- EUCRISA OINTMENT 2 % EXTERNAL
- *pimecrolimus cream 1 % external*
- *tacrolimus ointment 0.03 % external*
- *tacrolimus ointment 0.1 % external*

Details

| Criteria | |
|-----------------|---|
| | Claim will pay automatically for Eucrisa, pimecrolimus or tacrolimus external if enrollee has a paid claim for at least a 1 day supply of any formulary topical corticosteroid in the past 365 days. Otherwise, Eucrisa, pimecrolimus or tacrolimus external requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary topical corticosteroid, OR (2) history of adverse event with any formulary topical corticosteroid, OR (3) any formulary topical corticosteroid is contraindicated. |

**Provider Partners Health Plan of Ohio
2020 Formulary – Step Therapy Criteria**

UCERIS

Products Affected

Step 2:

- *budesonide er tablet extended release 24 hour 9 mg oral*
- UCERIS FOAM 2 MG/ACT RECTAL

Details

| Criteria | |
|----------|---|
| | Claim will pay automatically for Budesonide ER 9mg or Uceris Rectal Foam if enrollee has a paid claim for at least a 1 day supply of any formulary corticosteroid used to treat ulcerative colitis in the past 365 days. Otherwise, Budesonide ER 9mg or Uceris Rectal Foam requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary corticosteroid used to treat ulcerative colitis, OR (2) history of adverse event with any formulary corticosteroid used to treat ulcerative colitis, OR (3) any formulary corticosteroid used to treat ulcerative colitis is contraindicated. |

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ZYFLO

Products Affected

Step 2:

- *zileuton er tablet extended release 12 hour* • ZYFLO TABLET 600 MG ORAL
600 mg oral

Details

| | |
|-----------------|--|
| Criteria | Claim will pay automatically for Zyflo CR or zileuton if enrollee has a paid claim for at least a 1 day supply of montelukast or zafirlukast in the past 365 days. Otherwise, Zyflo CR or zileuton require a step therapy exception request indicating: (1) history of inadequate treatment response with montelukast or zafirlukast, OR (2) history of adverse event with montelukast or zafirlukast, OR (3) montelukast or zafirlukast is contraindicated. |
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Provider Partners Health Plan of Ohio 2020 Formulary – Step Therapy Criteria

Alphabetical Listing

A

ABILIFY MAINTENA PREFILLED
SYRINGE 300 MG INTRAMUSCULAR
..... 1, 5

ABILIFY MAINTENA PREFILLED
SYRINGE 400 MG INTRAMUSCULAR
..... 1, 5

ABILIFY MAINTENA SUSPENSION
RECONSTITUTED ER 300 MG
INTRAMUSCULAR..... 1, 5

ABILIFY MAINTENA SUSPENSION
RECONSTITUTED ER 400 MG
INTRAMUSCULAR..... 1, 5

ABILIFY MYCITE TABLET 10 MG
ORAL..... 1, 5

ABILIFY MYCITE TABLET 15 MG
ORAL..... 1, 5

ABILIFY MYCITE TABLET 2 MG ORAL
..... 1, 5

ABILIFY MYCITE TABLET 20 MG
ORAL..... 1, 5

ABILIFY MYCITE TABLET 30 MG
ORAL..... 1, 5

ABILIFY MYCITE TABLET 5 MG ORAL
..... 1, 5

B

budesonide er tablet extended release 24
hour 9 mg oral..... 20

C

CAPLYTA CAPSULE 42 MG ORAL... 1, 5

CONDYLOX GEL 0.5 % EXTERNAL... 12

D

DEXILANT CAPSULE DELAYED
RELEASE 30 MG ORAL..... 17

DEXILANT CAPSULE DELAYED
RELEASE 60 MG ORAL..... 17

DIFICID TABLET 200 MG ORAL 14

dihydroergotamine mesylate solution 4
mg/ml nasal..... 13

E

EUCRISA OINTMENT 2 % EXTERNAL
..... 19

F

FANAPT TABLET 1 MG ORAL 1, 5

FANAPT TABLET 10 MG ORAL 1, 5

FANAPT TABLET 12 MG ORAL 1, 5

FANAPT TABLET 2 MG ORAL 1, 5

FANAPT TABLET 4 MG ORAL 1, 5

FANAPT TABLET 6 MG ORAL 1, 5

FANAPT TABLET 8 MG ORAL 1, 5

FANAPT TITRATION PACK TABLET 1
& 2 & 4 & 6 MG ORAL..... 1, 5

I

INVEGA SUSTENNA SUSPENSION
PREFILLED SYRINGE 117
MG/0.75ML INTRAMUSCULAR 1, 5

INVEGA SUSTENNA SUSPENSION
PREFILLED SYRINGE 156 MG/ML
INTRAMUSCULAR 1, 5

INVEGA SUSTENNA SUSPENSION
PREFILLED SYRINGE 234 MG/1.5ML
INTRAMUSCULAR..... 1, 5

INVEGA SUSTENNA SUSPENSION
PREFILLED SYRINGE 39 MG/0.25ML
INTRAMUSCULAR 1, 5

INVEGA SUSTENNA SUSPENSION
PREFILLED SYRINGE 78 MG/0.5ML
INTRAMUSCULAR 2, 5

INVEGA TRINZA SUSPENSION
PREFILLED SYRINGE 273
MG/0.875ML INTRAMUSCULAR... 2, 5

INVEGA TRINZA SUSPENSION
PREFILLED SYRINGE 410
MG/1.315ML INTRAMUSCULAR... 2, 5

INVEGA TRINZA SUSPENSION
PREFILLED SYRINGE 546
MG/1.75ML INTRAMUSCULAR 2, 5

INVEGA TRINZA SUSPENSION
PREFILLED SYRINGE 819
MG/2.625ML INTRAMUSCULAR... 2, 5

L

LATUDA TABLET 120 MG ORAL 2, 5

LATUDA TABLET 20 MG ORAL 2, 5

LATUDA TABLET 40 MG ORAL 2, 5

LATUDA TABLET 60 MG ORAL 2, 5

Provider Partners Health Plan of Ohio 2020 Formulary – Step Therapy Criteria

| | | | |
|--------------------------------------|--------|---|------|
| LATUDA TABLET 80 MG ORAL | 2, 5 | RYTARY CAPSULE EXTENDED | |
| N | | RELEASE 23.75-95 MG ORAL | 18 |
| NEUPRO PATCH 24 HOUR 1 MG/24HR | | RYTARY CAPSULE EXTENDED | |
| TRANSDERMAL..... | 15, 16 | RELEASE 36.25-145 MG ORAL | 18 |
| NEUPRO PATCH 24 HOUR 2 MG/24HR | | RYTARY CAPSULE EXTENDED | |
| TRANSDERMAL..... | 15, 16 | RELEASE 48.75-195 MG ORAL | 18 |
| NEUPRO PATCH 24 HOUR 3 MG/24HR | | RYTARY CAPSULE EXTENDED | |
| TRANSDERMAL..... | 15, 16 | RELEASE 61.25-245 MG ORAL | 18 |
| NEUPRO PATCH 24 HOUR 4 MG/24HR | | S | |
| TRANSDERMAL..... | 15, 16 | SAPHRIS TABLET SUBLINGUAL 10 MG | |
| NEUPRO PATCH 24 HOUR 6 MG/24HR | | SUBLINGUAL | 3, 5 |
| TRANSDERMAL..... | 15, 16 | SAPHRIS TABLET SUBLINGUAL 2.5 | |
| NEUPRO PATCH 24 HOUR 8 MG/24HR | | MG SUBLINGUAL..... | 3, 5 |
| TRANSDERMAL..... | 15, 16 | SAPHRIS TABLET SUBLINGUAL 5 MG | |
| NUPLAZID CAPSULE 34 MG ORAL . | 2, 5 | SUBLINGUAL | 3, 5 |
| NUPLAZID TABLET 10 MG ORAL.... | 2, 5 | SECUADO PATCH 24 HOUR 3.8 | |
| P | | MG/24HR TRANSDERMAL | 3, 5 |
| PERSERIS PREFILLED SYRINGE 120 | | SECUADO PATCH 24 HOUR 5.7 | |
| MG SUBCUTANEOUS | 2, 5 | MG/24HR TRANSDERMAL | 3, 5 |
| PERSERIS PREFILLED SYRINGE 90 MG | | SECUADO PATCH 24 HOUR 7.6 | |
| SUBCUTANEOUS..... | 2, 5 | MG/24HR TRANSDERMAL | 3, 5 |
| pimecrolimus cream 1 % external..... | 19 | T | |
| R | | tacrolimus ointment 0.03 % external | 19 |
| REXULTI TABLET 0.25 MG ORAL.... | 2, 5 | tacrolimus ointment 0.1 % external | 19 |
| REXULTI TABLET 0.5 MG ORAL..... | 2, 5 | U | |
| REXULTI TABLET 1 MG ORAL..... | 2, 5 | UCERIS FOAM 2 MG/ACT RECTAL.... | 20 |
| REXULTI TABLET 2 MG ORAL..... | 2, 5 | V | |
| REXULTI TABLET 3 MG ORAL..... | 2, 5 | VERSACLOZ SUSPENSION 50 MG/ML | |
| REXULTI TABLET 4 MG ORAL..... | 2, 5 | ORAL..... | 3, 5 |
| RISPERDAL CONSTA SUSPENSION | | VRAYLAR CAPSULE 1.5 MG ORAL . | 3, 5 |
| RECONSTITUTED ER 12.5 MG | | VRAYLAR CAPSULE 3 MG ORAL | 3, 5 |
| INTRAMUSCULAR | 2, 5 | VRAYLAR CAPSULE 4.5 MG ORAL . | 3, 5 |
| RISPERDAL CONSTA SUSPENSION | | VRAYLAR CAPSULE 6 MG ORAL | 3, 5 |
| RECONSTITUTED ER 25 MG | | VRAYLAR CAPSULE THERAPY PACK | |
| INTRAMUSCULAR | 2, 5 | 1.5 & 3 MG ORAL | 3, 5 |
| RISPERDAL CONSTA SUSPENSION | | Z | |
| RECONSTITUTED ER 37.5 MG | | zileuton er tablet extended release 12 hour | |
| INTRAMUSCULAR | 2, 5 | 600 mg oral | 21 |
| RISPERDAL CONSTA SUSPENSION | | ZYFLO TABLET 600 MG ORAL | 21 |
| RECONSTITUTED ER 50 MG | | ZYPREXA RELPREVV SUSPENSION | |
| INTRAMUSCULAR | 2, 5 | RECONSTITUTED 210 MG | |
| | | INTRAMUSCULAR | 3, 5 |