COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

ANALGESICS, NARCOTICS

DRUG NAME

KADIAN | MORPHINE SULFATE ER

STEP THERAPY CRITERIA

PRIOR CLAIM FOR MORPHINE SULFATE SUSTAINED ACTION TABLET (MS CONTIN) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

ANTICONVULSANTS

DRUG NAME

BANZEL | VIMPAT

STEP THERAPY CRITERIA

PRIOR CLAIM FOR GENERIC ANTICONVULSANT AGENT (CARBAMAZEPINE, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, VALPROIC ACID, VALPROATE, TOPIRAMIDE, OR ZONISAMIDE) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

ANTIDIABETIC AGENTS - INSULINS

DRUG NAME

LEVEMIR

STEP THERAPY CRITERIA

PRIOR CLAIM FOR INSULIN GLARGINE (LANTUS OR LANTUS SOLOSTAR) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

ANTIPSYCHOTIC AGENTS

DRUG NAME

FANAPT | FAZACLO | INVEGA | LATUDA | SAPHRIS

STEP THERAPY CRITERIA

PRIOR CLAIM FOR RISPERIDONE TABLET, RISPERIDONE DISINTEGRATING TABLET, CLOZAPINE TABLET, CLOZAPINE ORAL DISINTEGRATING TABLET, OLANZAPINE TABLET, OLANZAPINE ORAL DISINTEGRATING TABLET, OR IMMEDIATE RELEASE QUETIAPINE FUMARATE WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

ANTIULCER AGENTS

DRUG NAME

DEXILANT | LANSOPRAZOLE

STEP THERAPY CRITERIA

PRIOR CLAIM FOR GENERIC FEDERAL LEGEND OMEPRAZOLE OR PANTOPRAZOLE WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

B VERSUS D ADMINISTRATIVE STEP

DRUG NAME

CYCLOPHOSPHAMIDE | METHOTREXATE | TREXALL

STEP THERAPY CRITERIA

PRIOR CLAIM FOR A RHEUMATOID ARTHRITIS DRUG WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

BISPHOSPHONATES

DRUG NAME

ACTONEL | BONIVA

STEP THERAPY CRITERIA

PRIOR CLAIM FOR GENERIC ALENDRONATE OR FOSAMAX ORAL SOLUTION WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

CONTRACEPTIVES

DRUG NAME

NUVARING | ORTHO EVRA

STEP THERAPY CRITERIA

PRIOR CLAIM FOR A GENERIC ORAL 21 OR 28 DAY CONTRACEPTIVE WITHIN THE PAST 120 DAYS. DOES NOT INCLUDE PLAN B OR PLAN B-ONE STEP OR THEIR GENERICS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

COPD

DRUG NAME

DALIRESP

STEP THERAPY CRITERIA

PRIOR CLAIM FOR INHALED TIOTROPIUM (SPIRIVA) AND AN INHALED LONG ACTING BETA AGONIST OR AN INHALED LONG ACTING BETA AGONIST COMBINATION WITHIN THE LAST 365 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

DIPEPTIDYL PEPTIDASE-4 ENZYME INHIBITORS

DRUG NAME

JANUMET | JANUMET XR | JANUVIA | JENTADUETO | JUVISYNC | KOMBIGLYZE XR | ONGLYZA | TRADJENTA

STEP THERAPY CRITERIA

PRIOR CLAIM FOR METFORMIN (GLUCOPHAGE), METFORMIN ER, GLYBURIDE/METFORMIN (GLUCOVANCE) OR GLIPIZIDE/METFORMIN (METAGLIP) WITHIN THE PAST 180 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

HYPERURICEMIC AGENTS

DRUG NAME

ULORIC

STEP THERAPY CRITERIA

PRIOR CLAIM FOR ALLOPURINOL OR COLCHICINE WITHIN THE PAST 120 DAYS

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

KETOLIDES

DRUG NAME

KETEK

STEP THERAPY CRITERIA

PRIOR CLAIM FOR A MACROLIDE WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

LHRH AGONISTS

DRUG NAME

LUPRON DEPOT | LUPRON DEPOT-PED | TRELSTAR

STEP THERAPY CRITERIA

PRIOR CLAIM FOR ELIGARD (LEUPROLIDE) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

MEGLITINIDES

DRUG NAME

PRANDIMET | PRANDIN

STEP THERAPY CRITERIA

PRIOR CLAIM FOR METFORMIN (GLUCOPHAGE), METFORMIN ER, GLYBURIDE/METFORMIN (GLUCOVANCE), GLIPIZIDE/METFORMIN (METAGLIP) OR A FORMULARY ORAL SULFONYLUREA (E.G., GLYBURIDE, GLIPIZIDE) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

MIOTICS/OTHER INTRAOCULAR PRESSURE REDUCERS

DRUG NAME

BETIMOL

STEP THERAPY CRITERIA

PRIOR CLAIM FOR A GENERIC OR FORMULARY BRAND MIOTIC/OTHER INTRAOCULAR PRESSURE REDUCER OR LATANOPROST (XALATAN) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

MULTIPLE SCLEROSIS AGENTS

DRUG NAME

BETASERON | EXTAVIA

STEP THERAPY CRITERIA

PRIOR CLAIM FOR REBIF (INTERFERON BETA-1A) OR AVONEX (INTERFERON BETA-1A) OR COPAXONE (GLATIRAMIR ACETATE) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

NSAID-PPI COMBINATION

DRUG NAME

VIMOVO

STEP THERAPY CRITERIA

PRIOR CLAIM FOR GENERIC NAPROXEN WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE

DRUG NAME

CELEBREX

STEP THERAPY CRITERIA

PRIOR CLAIM FOR ONE (1) NON-STEROIDAL ANTI-INFLAMMATORY AGENTS WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

OPHTHALMIC ANTIHISTAMINES

DRUG NAME

PATADAY | PATANOL

STEP THERAPY CRITERIA

PRIOR CLAIM FOR OTC LORATADINE, LORATADINE D, CETIRIZINE, CETIRIZINE D, OR GENERIC KETOTIFEN EYE DROPS (ALAWAY) OR PRESCRIPTION FEXOFENADINE, LEVOCETIRIZINE OR CROMOLYN SODIUM EYE DROPS WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

OPHTHALMIC MAST CELL STABILIZERS

DRUG NAME

ALAMAST

STEP THERAPY CRITERIA

PRIOR CLAIM FOR OPHTHALMIC CROMOLYN SODIUM WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

RENIN ANGIOTENSION SYSTEM INHIBITORS

DRUG NAME

AZOR | BENICAR | BENICAR HCT | DIOVAN | DIOVAN HCT | EXFORGE | EXFORGE HCT | TRIBENZOR

STEP THERAPY CRITERIA

PRIOR CLAIM FOR AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE INHIBITOR), OR ACE INHIBITOR COMBINATION OR A GENERIC ANGIOTENSIN RECEPTOR BLOCKER (ARB), OR GENERIC ARB COMBINATION WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

SELECTIVE SEROTONIN REUPTAKE-INHIBITORS (SSRIS)

DRUG NAME

LEXAPRO | LUVOX CR

STEP THERAPY CRITERIA

PRIOR CLAIM FOR PAROXETINE (PAXIL), FLUOXETINE (PROZAC), CITALOPRAM (CELEXA), FLUVOXAMINE (LUVOX) OR SERTRALINE (ZOLOFT) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

SEROTONIN 5-HT AGONISTS

DRUG NAME

MAXALT | MAXALT MLT | RELPAX

STEP THERAPY CRITERIA

PRIOR CLAIM FOR GENERIC SUMATRIPTAN OR NARATRIPTAN IN THE LAST 180 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIBITORS (SNRIS)

DRUG NAME

PRISTIQ ER

STEP THERAPY CRITERIA

PRIOR CLAIM FOR PAROXETINE (PAXIL), FLUOXETINE (PROZAC), SERTRALINE (ZOLOFT), CITALOPRAM (CELEXA), FLUVOXAMINE (LUVOX) OR VENLAFAXINE (EFFEXOR IMMEDIATE RELEASE) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

THIAZOLIDINEDIONES

DRUG NAME

ACTOPLUS MET | ACTOPLUS MET XR | ACTOS | AVANDAMET | AVANDARYL | AVANDIA | DUETACT

STEP THERAPY CRITERIA

PRIOR CLAIM FOR METFORMIN (GLUCOPHAGE), METFORMIN ER, GLYBURIDE/METFORMIN (GLUCOVANCE), GLIPIZIDE/METFORMIN (METAGLIP) OR A FORMULARY ORAL SULFONYLUREA (E.G., GLYBURIDE, GLIPIZIDE) WITHIN THE PAST 120 DAYS.

COMMUNITY HEALTH GROUP
Step Therapy Requirements

Effective Date: 05/01/2012

STEP THERAPY GROUP DESCRIPTION

TOPICAL NSAID THERAPY AGENTS

DRUG NAME

VOLTAREN

STEP THERAPY CRITERIA

PRIOR CLAIM FOR AN ORAL NON-STEROIDAL ANTI-INFLAMMATORY AGENT (E.G., IBUPROFEN, NAPROSYN) WITHIN THE PAST 120 DAYS.