



L.A. Care
HEALTH PLAN®

L. A. Care Health Plan Medicare Advantage HMO
Drugs Requiring Step Therapy Effective 03/01/2010

Medicare Part D		
Step Therapy Group Desc	Drugs Name	Step Therapy Criteria
ANALGESICS, NARCOTICS	KADIAN	PRIOR CLAIM FOR MORPHINE SULFATE SUSTAINED ACTION TABLET (MS CONTIN) WITHIN THE PAST 120 DAYS
ANTIPSYCHOTICS ATYPICAL DOPAMINE AND SEROTONIN ANTAGONISTS	INVEGA INVEGA SUSTENNA	PRIOR CLAIM FOR RISPERIDONE (RISPERDAL), CLOZAPINE (CLOZARIL, FAZACLO), QUETIAPINE (SEROQUEL), ARIPIPIRAZOLE (ABILIFY) OLANZAPINE (ZYPREXA, ZYPREXA ZYDIS), OR ZIPRASIDONE (GEODON) WITHIN THE PAST 120 DAYS.
B VERSUS D ADMINISTRATIVE STEP	CYCLOPHOSPHAMIDE METHOTREXATE TREXALL	PRIOR CLAIM FOR A RHEUMATOID ARTHRITIS DRUG WITHIN THE PAST 120 DAYS.
BYETTA	BYETTA	PRIOR CLAIM FOR METFORMIN, A SULFONYLUREA (I.E., GLIPIZIDE, GLYBURIDE), OR A THIAZOLIDINEDIONE (I.E., PIOGLITAZONE, ROSIGLITAZONE) WITHIN THE PAST 120 DAYS.

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DIPEPTIDYL PEPTIDASE-4 ENZYME INHIBITORS	JANUMET JANUVIA ONGLYZA	PRIOR CLAIM FOR METFORMIN (GLUCOPHAGE), METFORMIN ER, GLYBURIDE/METFORMIN (GLUCOVANCE) OR GLIPIZIDE/METFORMIN (METAGLIP) WITHIN THE PAST 180 DAYS.
DIRECT RENIN INHIBITORS	TEKTRNA TEKTRNA HCT VALTRNA	PRIOR CLAIM FOR A FORMULARY ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE INHIBITOR) OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) WITHIN THE PAST 120 DAYS.
HYPERURICEMIC AGENTS	ULORIC	PRIOR CLAIM FOR ALLOPURINOL OR COLCHICINE WITHIN THE PAST 120 DAYS
KERATOPLASTIC AGENTS	VECTICAL	PRIOR CLAIM FOR TOPICAL CALCIPOTRIENE (DOVONEX) WITHIN THE PAST 120 DAYS.
KETOLIDES	KETEK	PRIOR CLAIM FOR A MACROLIDE WITHIN THE PAST 120 DAYS.
LEUKOTRIENE RECEPTOR ANTAGONISTS	ACCOLATE SINGULAIR	PRIOR CLAIM FOR A NON-SEDATING ANTIHISTAMINE OR ASTHMA AGENT (E.G., ORAL INHALED CORTICOSTEROIDS, BETA-ADRENERGIC AGENTS, OMALIZUMAB [XOLAIR] OR BUDESONIDE [PULMICORT]) WITHIN THE PAST 180 DAYS.
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE	CELEBREX	PRIOR CLAIM FOR ONE (1) SEPARATE NON-STEROIDAL ANTI-INFLAMMATORY AGENTS WITHIN THE PAST 120 DAYS.

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OPHTHALMIC ANTIHISTAMINES	PATADAY PATANOL	PRIOR PRESCRIPTION FOR PRESCRIPTION FEXOFENADINE OR CROMOLYN SODIUM EYE DROPS WITHIN THE PAST 120 DAYS.
THIAZOLIDINEDIONES	ACTOPLUS MET ACTOS AVANDAMET AVANDARYL AVANDIA DUETACT	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.
TOPICAL NSAID THERAPY AGENTS	VOLTAREN	PRIOR CLAIM FOR A GENERIC ORAL NON-STEROIDAL ANTI-INFLAMMATORY AGENT (E.G., IBUPROFEN, NAPROSYN) WITHIN THE PAST 120 DAYS.