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Drugs That Require Step Therapy (ST) Before Being Approved for Coverage

In some cases, AvMed Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Step-1 and Step-2 drugs both treat your medical condition, we may not cover the Step-2 drug unless you try the Step-1 drug first. If the Step-1 drug does not work for you, we will then cover the Step-2 drug.

You will need authorization from AvMed Medicare before filling prescriptions for the Step-2 drugs shown in the chart that begins on the next page. AvMed Medicare will only provide coverage after it determines that the drug is being prescribed according to the criteria specified in the chart.

You, your appointed representative, or your prescriber can request prior authorization by calling AvMed at 1-800-782-8633, October 1 - March 31, 8:00 AM-8:00 PM, seven days a week, and April 1 - September 30, 8:00 AM - 8:00 PM Monday - Friday, 9:00 AM - 1:00 PM Saturday. Customer Service is available in English and other languages. TTY users should call 711.

Step Therapy Criteria

Step Therapy Group BISPHOSPHONATES
Drug Names FOSAMAX PLUS D
Step Therapy Criteria Coverage will be provided if alendronate, ibandronate, or risedronate has been tried (at least a 30 day supply in the prior 180 days).

Step Therapy Group HMG-COA INHIBITORS
Drug Names ALTOPREV, EZALLOR SPRINKLE, LIVALO, ZYPITAMAG
Step Therapy Criteria Coverage will be provided if atorvastatin, ezetimibe/simvastatin, fluvastatin, fluvastatin extended-release, lovastatin, pravastatin, rosuvastatin tablets, simvastatin tablets, or amlodipine/atorvastatin has been tried (at least a 30-day supply) in the prior 180 days.

Step Therapy Group LEVALBUTEROL
Drug Names LEVALBUTEROL TARTRATE HFA
Step Therapy Criteria Coverage will be provided if albuterol HFA or Ventolin HFA have been tried (at least a 30-day supply) in the prior 180 days.

Step Therapy Group NASAL STEROIDS
Drug Names MOMETASONE FUROATE, OMNARIS
Step Therapy Criteria Coverage will be provided if generic fluticasone nasal spray has been tried (at least a 30-day supply) in the prior 180 days.

Step Therapy Group PPI
Drug Names ESOMEPRAZOLE MAGNESIUM, LANSOPRAZOLE
Step Therapy Criteria Coverage will be provided if two of the following generic alternatives: omeprazole capsules, pantoprazole tablets, or lansoprazole capsules have been tried (at least a 30 day supply in the prior 180 days).

Step Therapy Group URINARY ANTISPASMODICS
Drug Names DARIFENACIN HYDROBROMIDE, TOLTERODINE TARTRATE ER
Step Therapy Criteria Coverage will be provided if fesoterodine, mirabegron, oxybutynin, oxybutynin extended-release, solifenacin tablets, tolterodine tablets, trospium immediate-release, or vibegron has been tried (at least a 30-day supply in the prior 180 days).