



Coverage Policy/Guideline

Name: Step Therapy Drugs Page: 1 of 2

Effective Date: 10/1/2025 Last Review Date: 9/2025

Applies to: Illinois Florida Florida Kids
 New Jersey Maryland Michigan
 Pennsylvania Kids Virginia Arizona

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for step therapy drugs under the patient’s prescription drug benefit.

Description:

Medications that require step therapy require trial and failure of prerequisite drugs prior to their authorization. If the prerequisite drugs have been filled within the specified timeframe, the prescription will automatically process at the pharmacy. Prior authorization will be required for drugs that do not process automatically at the pharmacy.

Applicable Drug List:

TARGET DRUG (Step 2)	Prerequisite drug(s) (Step 1)	Look back days	Required Days supply
PARICALCITOL CAPSULE	Calcitriol capsule	130	30
CANDESARTAN CILEXETIL TABLET CANDESARTAN CILEXETIL-HCTZ TABLET	Any 2 of the following: losartan potassium tablet, olmesartan medoxomil tablet, valsartan tablet, irbesartan-HCTZ tablet, losartan potassium-HCTZ tablet, or valsartan-HCTZ tablet	180	30
BIMATOPROST OPHTH SOLN 0.03%	Latanoprost ophth soln 0.005%	130	30
DICLOFENAC SODIUM SOLUTION 1.5%	Diclofenac sodium gel 1%	130	30
MALATHION LOTION	permethrin creme rinse, permethrin cream, pyrethrins-piperonyl butoxide shampoo	60	1

Policy/Guideline:

Authorization of a step therapy drug will be approved for members:

- who have tried the required prerequisite drug or drugs for the required days supply within the required look back timeframe.

OR



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- who have a contradiction to the prerequisite drug or the prerequisite drug is clinically inappropriate.

Documentation is required for approval.

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

References:

ABH PDL