GENERIC STEP THERAPY PLANS (GSTP)

DRUG CLASS **PROSTAGLANDIN ANALOGUES AND COMBINATIONS**

HPGST SSB – Ref# 612-D: **Lumigan, Rocklatan, Xelpros, Vyzulta**

TGST SSB – Ref# 613-D: **Lumigan, Rocklatan, Xelpros, Vyzulta**

Status: CVS Caremark Criteria
Type: Initial Step Therapy; Post Step Therapy Prior Authorization

INITIAL STEP THERAPY

If the patient has filled a prescription for at least a 30 day supply of at least one generic prostaglandin analogue drug within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

The requested branded prostaglandin analogue drug will be covered with post step therapy prior authorization when the following criteria are met:

- The patient has experienced an inadequate treatment response after at least a 30 day trial of at least one generic prostaglandin analogue drug
  OR
- The patient has a documented contraindication or a potential drug interaction that would prohibit a trial of at least one generic prostaglandin analogue drug
  OR
- The patient has experienced an intolerance to at least one generic prostaglandin analogue drug

RATIONALE

If the patient has filled a prescription for at least a 30 day supply of at least one generic prostaglandin analogue drug within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit.

If the patient does not meet the initial step therapy criteria, then prior authorization is required.

If the patient has a documented contraindication or a potential drug interaction that would prohibit a trial of at least one generic drug, then the requested brand drug will be covered. If the patient is intolerant to at least one of the generic drugs, then the requested brand drug will be covered. If the patient has tried at least one of the generic drugs for at least 30 days and had an inadequate treatment response, then the requested brand drug will be covered. If these requirements are met, then the approval duration is 24 months.

REFERENCES

N/A

Written by: UM Development (NB)
Date Written: 01/2011

CVS caremark®

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Reviewed:	Medical Affairs 01/2011, (KP) 02/2012, 04/2012; (DC) 09/2012, (LS) 02/2013, (LS) 11/2013, (DC) 11/2014, (EPA) 07/2019, (CHART) 10/31/2019, (CHART) 10/29/2020, (CHART) 10/28/2021, 10/27/2022, 01/12/2023
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CRITERIA FOR APPROVAL

1	Has the patient experienced an inadequate treatment response after at least a 30 day trial of at least one generic prostaglandin analogue drug? [If yes, then no further questions.]	Yes	No
2	Does the patient have a documented contraindication or a potential drug interaction that would prohibit a trial of at least one generic prostaglandin analogue drug? [If yes, then no further questions.]	Yes	No
3	Has the patient experienced an intolerance to at least one generic prostaglandin analogue drug?	Yes	No

Mapping Instructions		
	Yes	**No**
1	Approve, 24 months	Go to 2
2	Approve, 24 months	Go to 3
3	Approve, 24 months	Deny