



Effective Date05/01/2026
Coverage Policy Number 1803

Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans)

Table of Contents

Overview.....	1
Coverage Policy.....	1
References	9
Revision Details.....	10

Related Coverage Resources

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see “Coding Information” below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

Employer Group Plans have a Prescription Drug List that subjects certain brand name drugs to step therapy requiring medical necessity review.

Coverage Policy

Cigna approves coverage for these brand name drugs as medically necessary when there is a documented failure, inadequate response, contraindication per FDA label, or intolerance to the number of Step 1 and/or Step 2 drugs, or as otherwise specified in the table below.

Step Therapy (ST) definitions:

- **Step 1 Medications** – These medications do not require Step Therapy, are automatically covered, and do not require prior authorization.
- **Step 2 Medications** – Usually brand name medications. These medications do not require Step Therapy, are automatically covered, and do not require prior authorization.
- **Step 3 Medications** – Usually brand name medications. These medications require Step Therapy. If the physician determines the treatment plan should begin with a Step 3 medication, a request for authorization will need to be submitted and approved.

(Note: Not all plans will use all Step Therapy classes in the table below. Where noted, certain benefit plans may require different numbers of alternatives as prerequisite therapy.)

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Note: Receipt of sample product does not satisfy any criteria requirements for coverage.

**Cigna Employer Group Plans:
Legacy Prescription Drug Lists**

Acne, Oral Complete Plan: Requires ONE Step 1 agent Essential Plan: Requires ONE Step 1 agent Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • Claravis • Isotretinoin (generic for Absorica) • Myorisan • Zenatane 		<ul style="list-style-type: none"> • Absorica LD
5-Aminosalicylates (5-ASAs) Complete Plan: Requires ONE Step 1 agent Essential Plan: Requires ONE Step 1 agent Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • balsalazide • mesalamine (oral) 		<ul style="list-style-type: none"> • Asacol HD 800MG • Colazal • Delzicol • Dipentum • Lialda • Pentasa 250 mg
Angiotensin Converting Enzyme Inhibitors/Angiotensin Receptor Blockers (ACE/ARB) Complete Plan: Requires TWO Step 1 agents Essential Plan: Requires TWO Step 1 agents Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • benazepril (generic lotensin) • benazepril/HCTZ (generic Lotensin HCT) • candesartan (generic Atacand) • candesartan/HCTZ (generic Atacand HCT) • captopril (generic Capoten) • captopril/HCTZ (generic Capozide) • enalapril (generic Vasotec) • enalapril/HCTZ (generic Vaseretic) 		<ul style="list-style-type: none"> • Accupril • Accuretic • Lotensin • Lotensin HCT • Micardis HCT • Prinivil • valsartan oral solution • Vaseretic

<ul style="list-style-type: none"> • eprosartan (generic Teveten) • fosinopril (generic Monopril) • fosinopril/HCTZ (generic Monopril HCT) • irbesartan (generic Avapro) • irbesartan/HCTZ (generic Avalide) • lisinopril (generic Prinivil/Zestril) • lisinopril/HCTZ (generic Zesteretic) • losartan (generic Cozaar) • losartan/hctz (generic Hyzaar) • moexipril • moexipril/HCTZ • olmesartan (generic Benicar) • olmesartan/HCTZ (generic Benicar HCT) • perindopril • quinapril (generic Accupril) • quinapril/hctz (generic Accuretic) • ramipril (generic Altace) • telmisartan (generic Micardis) • telmisartan/hctz (generic Micardis HCT) • trandolapril (generic Mavik) • valsartan (generic Diovan) tablets • valsartan/hctz (generic Diovan HCT) 		<ul style="list-style-type: none"> • Zestoretic
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Antidepressants

Complete Plan: Requires THREE Step 1 agents unless specified below

Essential Plan: Requires THREE Step 1 agents unless specified below

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • bupropion (Wellbutrin/Wellbutrin SR/Wellbutrin XL) • citalopram (generic Celexa) • desvenlafaxine succ ER (generic Pristiq) • duloxetine (generic Cymbalta and Irenka) • escitalopram (generic Lexapro) • fluoxetine (generic Prozac/Prozac Weekly/Sarafem) • fluvoxamine • paroxetine (generic Paxil/Paxil CR) • sertraline (generic Zoloft) • vilazodone (generic Viibryd) 		<ul style="list-style-type: none"> • Auvelity (Requires ONE Step 1 Medication) • Drizalma Sprinkle

An exception to the criteria will be provided when an individual is not a candidate for (e.g., stabilized condition where therapeutic interchange is inappropriate) the Step Therapy requirements.

Anti-Parkinsonism Drugs (Monoamine Oxidase Type B (MAO-B) Inhibitors)

Complete Plan: Requires ONE Step 1 agent

Essential Plan: N/A

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • selegiline 		<ul style="list-style-type: none"> • Xadago

Attention Deficit Hyperactive Disorder (ADHD)

Complete Plan: N/A

Essential Plan: Requires FOUR Step 1 agents unless specified below

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> amphetamine sulfate (generic Evekeo) amphetamine/dextroamphetamine (generic Adderall) amphetamine/dextroamphetamine ER (generic Adderall XR) d-amphetamine (generic Dexedrine/Dextrostat) dexmethylphenidate (generic Focalin) dexmethylphenidate er (generic Focalin XR) dextroamphetamine (generic for Zenedi) lisdexamphetamine dimesylate capsules or chewable tablets (generic for Vyvanse) methamphetamine (generic Desoxyn) methylphenidate (generic Ritalin) methylphenidate CD/ER/LA/SA (generic Ritalin LA/Concerta) mixed salts of a single-entity amphetamine product extended-release capsules (generic for Mydayis) 		<ul style="list-style-type: none"> Adderall XR Adhansia XR Aptensio XR Azstarys (Requires ONE Step 1 Medication) Concerta Focalin Focalin XR Jornay PM (Requires ONE Step 1 Medication) Ritalin Ritalin LA Zenedi

An exception to the criteria will be provided when an individual is not a candidate for (e.g., stabilized condition where therapeutic interchange is inappropriate) the Step Therapy requirements.

Atypical Antipsychotic Agents

Complete Plan: Requires ONE Step 1 agent

Essential Plan: Requires ONE Step 1 agent

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> aripiprazole (generic Abilify) clozapine (generic Clozaril) clozapine ODT (generic Fazaclo) lurasidone (generic Latuda) olanzapine/olanzapine ODT (generic Zyprexa/Zyprexa Zydis) paliperidone (generic Invega) pimozide quetiapine (generic Seroquel) quetiapine ER (generic Seroquel XR) risperidone (generic Risperdal/Risperdal M) risperidone ODT ziprasidone (generic Geodon) 		<ul style="list-style-type: none"> Abilify Caplyta Lybalvi Rexulti Saphris Secuado Patch Seroquel Seroquel XR Vraylar

An exception to the criteria will be provided when an individual is not a candidate for (e.g., stabilized condition where therapeutic interchange is inappropriate) the Step Therapy requirements.

Diabetes Care

Complete Plan: Requires ONE Step 1 agent

Essential Plan: Requires ONE Step 1 agent

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> metformin 		<ul style="list-style-type: none"> Farxiga Glyxambi

		<ul style="list-style-type: none"> • Janumet • Janumet XR • Januvia • Jardiance • Qtern • Steglujan • Synjardy • Synjardy XR • Trijardy XR • Xigduo XR
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Note: The metformin step requirement criteria applies to new starts only.

An exception to Step Therapy criteria will be provided when ONE of the following are met:

1. The patient will be initiating dual therapy with metformin AND Farxiga or Jardiance, approve Farxiga or Jardiance.
2. The patient has a contraindication to metformin, according to the prescriber, approve Farxiga or Jardiance.
Note: Examples of contraindications to metformin include acute or chronic metabolic acidosis, including diabetic ketoacidosis.
3. If the patient has heart failure with reduced ejection fraction, approve Farxiga or Jardiance.
4. If the patient has heart failure with preserved ejection fraction, approve Farxiga or Jardiance.
5. If the patient has chronic kidney disease, approve Farxiga or Jardiance.
6. If the patient has atherosclerotic cardiovascular disease or, according to the prescriber, the patient has at least two risk factors for cardiovascular disease, approve Farxiga or Jardiance.

Fibrates-Standard Dose

Complete Plan: Requires THREE Step 1 agents

Essential Plan: N/A

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • fenofibrate: 120mg, 150mg, 160mg • fenofibrate micronized: 130mg, 134mg, 200mg • fenofibrate nanocrystallized: 145mg • fenofibric acid 105mg • fenofibric acid DR 135mg 		<ul style="list-style-type: none"> • Fibracor 105 Mg Tablet • Lipofen 150 Mg Capsule • Tricor 145 Mg Tablet • Trilipix DR 135 Mg Capsule • Triglide

Fibrates-Low Dose

Complete Plan: Requires THREE Step 1 agents

Essential Plan: N/A

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • fenofibrate : 40mg, 50mg, 54mg • fenofibrate micronized: 43mg, 67mg • fenofibrate nanocrystallized: 48mg • fenofibric acid 35mg • fenofibric acid DR 45mg 		<ul style="list-style-type: none"> • Fibracor 35 Mg Tablet • Lipofen 50 Mg Capsule • Tricor 48 Mg Tablet • Trilipix DR 45 Mg Capsule

Hypnotics

Complete Plan: Requires ONE Step 1 agent

Essential Plan: Requires ONE Step 1 agent

Limited Plan: N/A

Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • doxepin (generic Silenor) • eszopiclone (generic Lunesta) • ramelteon (generic Rozerem) • zaleplon (generic Sonata) 		<ul style="list-style-type: none"> • Dayvigo • Sonata

<ul style="list-style-type: none"> • zolpidem (generic Ambien and Intermezzo) • zolpidem er (generic Ambien CR) 		
Nasal Steroids Complete Plan: Requires TWO Step 1 agents Essential Plan: Requires TWO Step 1 agents Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • azelastine/fluticasone 137-50 mcg nasal spray (generic Dymista) • flunisolide (generic Nasarel) • fluticasone • mometasone (generic Nasonex) 		<ul style="list-style-type: none"> • Beconase AQ • Dymista • Nasonex • Omnaris • QNASL • Xhance • Zetonna
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Complete Plan: Requires TWO Step 1 agents Essential Plan: Requires TWO Step 1 agents Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • celecoxib (generic Celebrex) • diclofenac (generic Voltaren/Voltaren-XR) • diclofenac/misoprostol (generic Arthrotec) • etodolac (generic Lodine/Lodine XL) • fenoprofen calcium 600mg • flurbiprofen (generic Ansaid) • ibuprofen (generic Motrin) • indomethacin (generic Indocin/Indocin SR) • ketoprofen (generic Oruvail) 50mg, 75mg • meclofenamate sodium • mefenamic acid • meloxicam (generic Mobic) • nabumetone • naproxen tablets (generic Naprosyn/EC-Naprosyn/Anaprox) • oxaprozin (generic Daypro) • piroxicam (generic Feldene) • sulindac (generic Clinoril) • tolmetin (generic Tolectin/Tolectin DS) 		<ul style="list-style-type: none"> • Anaprox DS • Arthrotec 50 • Arthrotec 75 • Daypro • EC-Naprosyn • Feldene • Lodine • Mobic • Nalfon 600mg • Naprosyn tablets • Qmiiz ODT • Voltaren • Voltaren XR
Ophthalmic Corticosteroids Complete Plan: Requires TWO Step 1 agents Essential Plan: Requires TWO Step 1 agents Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> • dexamethasone sodium phosphate ophthalmic solution 0.1% • difluprednate ophthalmic emulsion 0.05% • fluorometholone ophthalmic suspension 0.1% • loteprednol ophthalmic gel 0.5% • loteprednol etabonate ophthalmic suspension 0.5% 		<ul style="list-style-type: none"> • Inveltys 1% ophthalmic suspension • Lotemax 0.5% ophthalmic ointment • Lotemax SM 0.38% ophthalmic gel

<ul style="list-style-type: none"> prednisolone acetate ophthalmic suspension 1% prednisolone sodium ophthalmic solution 1% 		
<p>An exception to Step Therapy criteria for Lotemax ophthalmic ointment will be provided when the following is met:</p> <ol style="list-style-type: none"> The patient has an allergy to benzalkonium chloride 		
Osteoporosis Complete Plan: Requires ONE Step 1 agent Essential Plan: Requires ONE Step 1 agent Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> alendronate (generic Fosamax) ibandronate (generic Boniva) risedronate (generic Actonel and Atelvia) 		<ul style="list-style-type: none"> Atelvia Binosto Boniva Fosamax Fosamax Plus D
Respiratory		
Step 1 Medications	Step 2 Medications	Step 3 Medications
Inhaled Corticosteroid (ICS) Complete Plan: Requires ONE Step 2 agent Essential Plan: Requires ONE Step 2 agent Limited Plan: N/A		
	<ul style="list-style-type: none"> Alvesco Asmanex QVAR 	<ul style="list-style-type: none"> ArmonAir DigiHaler Arnuity Ellipta Fluticasone furoate (generic for Arnuity Ellipta)
<p>An exception to Step Therapy criteria will be provided when the patient is pregnant and is currently receiving the requested product for asthma.</p>		
Inhaled Corticosteroid (ICS) with Long-Acting Beta Agonist (LABA) Complete Plan: Requires ONE Step 1 or ONE Step 2 agent unless specified below Essential Plan: Requires ONE Step 1 or ONE Step 2 agent unless specified below Limited Plan: N/A		
<ul style="list-style-type: none"> budesonide-formoterol (generic Symbicort) Wixela Inhub/fluticasone-salmeterol (Generic Advair Diskus) 	<ul style="list-style-type: none"> Advair HFA Breo Ellipta Dulera 	<ul style="list-style-type: none"> Advair Diskus AirDuo RespiClick AirDuo DigiHaler (requires ONLY Wixela Inhub/fluticasone-salmeterol (Generic Advair Diskus) Symbicort
Long-Acting Beta Agonist (LABA) Complete Plan: Requires ONE Step 2 agent Essential Plan: Requires ONE Step 2 agent Limited Plan: N/A		
	<ul style="list-style-type: none"> Striverdi Respimat 	<ul style="list-style-type: none"> Serevent Diskus
Long Acting Muscarinic Antagonist (LAMA) Complete Plan: Requires ONE Step 2 agent Essential Plan: Requires ONE Step 2 agent Limited Plan: N/A		

	<ul style="list-style-type: none"> Incruse Ellipta Spiriva Respimat 	<ul style="list-style-type: none"> Seebri Neohaler Tudorza Pressair
Statins Complete Plan: Requires TWO Step 1 agents unless specified below Essential Plan: Requires TWO Step 1 agents unless specified below Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<ul style="list-style-type: none"> atorvastatin (generic Lipitor) ezetimibe-simvastatin (generic Vytorin) fluvastatin/ fluvastatin ER (generic Lescol/Lescol XL) lovastatin pitavastatin (generic for Livalo) pravastatin (generic Pravachol) rosuvastatin calcium (generic Crestor) simvastatin (generic Zocor) 		<ul style="list-style-type: none"> Altoprev Atorvaliq* Ezallor Sprinkle* FloLipid* Zypitamag
*An exception to the Step Therapy requirement criteria may be provided if individual has documented inability to take tablet and capsule formulations		
Tetracycline and Oral Acne Class <u>Complete and Essential plans: Tetracycline, Doxycycline</u> Requires ONE Step 1 medication <u>Complete and Essential plans: Tetracycline, Acne, Oral</u> Requires THREE Step 1 medications Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
<u>Tetracycline, Doxycycline</u>		<u>Tetracycline, Doxycycline</u>
<ul style="list-style-type: none"> doxycycline 		<ul style="list-style-type: none"> Acticlate
<u>Tetracyclines, Acne, Oral</u>		<u>Tetracyclines, Acne, Oral</u>
<ul style="list-style-type: none"> doxycycline minocycline minocycline ER tablets 		<ul style="list-style-type: none"> Minolira ER Ximino Minocycline ER 105 mg, 135 mg tablets (generic for Minolira ER)
Topical Inflammatory Complete Plan: Requires THREE Step 1 agents Essential Plan: Requires THREE Step 1 agents Limited Plan: N/A		
Step 1 Medications	Step 2 Medications	Step 3 Medications
Topical Inflammatory, Very High Potency		
<ul style="list-style-type: none"> betamethasone dipropionate, augmented 0.05% gel, ointment, lotion clobetasol propionate 0.05% cream, foam, ointment, gel, lotion, shampoo, solution, spray fluocinonide 0.1% cream halobetasol propionate 0.05% cream, ointment 		<ul style="list-style-type: none"> Bryhali 0.01% Lotion Clodan 0.05% Kit Diprolene 0.05% Ointment Temovate 0.05% Cream, Ointment Ultravate 0.05% Cream, Ointment
Topical Inflammatory, High Potency		
<ul style="list-style-type: none"> amcinonide 0.1% cream, lotion, ointment 		<ul style="list-style-type: none"> Halog 0.1% Solution

<ul style="list-style-type: none"> • betamethasone dipropionate 0.05% ointment • betamethasone dipropionate, augmented 0.05% cream • desoximetasone 0.05% gel, ointment • desoximetasone 0.25% cream, ointment, spray • fluocinonide 0.05% cream, gel, ointment, solution • triamcinolone acetonide 0.5% cream, ointment 		<ul style="list-style-type: none"> • Topicort 0.05% Gel, Ointment • Topicort 0.25% Cream, Ointment, Spray
Topical Inflammatory, Medium Potency		
<ul style="list-style-type: none"> • betamethasone dipropionate 0.05% cream, lotion, spray • betamethasone valerate 0.1% cream, foam • clocortolone pivalate 0.1% cream • desoximetasone 0.05% cream • fluocinolone acetonide 0.025% cream, ointment • fluocinonide 0.05% cream (emollient base) • fluticasone propionate 0.005% ointment, cream, lotion • hydrocortisone butyrate 0.1% cream, lotion, ointment, solution • hydrocortisone valerate 0.2% cream, ointment • mometasone furoate 0.1% cream, lotion, ointment • prednicarbate 0.1% cream, ointment • triamcinolone acetonide 0.025% cream, lotion, ointment • triamcinolone acetonide 0.1% cream, lotion, ointment 		<ul style="list-style-type: none"> • Cloderm 0.1% Cream, Cream Pump • Dermasorb TA • Dermatop • Elocon • Luxiq 0.12% Foam • Synalar 0.025% Cream, Cream Kit, Ointment, Ointment Kit • Topicort 0.05% Cream
Topical Inflammatory, Low Potency		
<ul style="list-style-type: none"> • alclometasone dipropionate 0.05% cream and ointment • betamethasone valerate 0.1% lotion • desonide 0.05% cream, lotion, ointment, gel • fluocinolone acetonide 0.01% cream, oil, solution • hydrocortisone cream, lotion, ointment 		<ul style="list-style-type: none"> • Ala-Scalp 2% Lotion • Capex Shampoo • Derma-Smoothe-FS Body Oil, Scalp Oil • Dermasorb HC • Desonate 0.05% Gel • Nucort Lotion • Scalacort Dk 2% Kit • Synalar 0.01% Solution • Synalar Ts 0.01% Kit • Texacort 2.5% Solution

References

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2. Drug Facts and Comparisons. Facts & Comparisons® eAnswers [online]. Available from Wolters Kluwer Health, Inc.

3. U.S. Food and Drug Administration. Drugs@FDA. U.S. Department of Health & Human Services: <http://www.accessdata.fda.gov/scripts/cder/drugsatfda/>
4. U.S. Food and Drug Administration. Drugs@FDA. U.S. Department of Health & Human Services: Vyvanse https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021977s045,208510s001lbl.pdf
5. U.S. Food and Drug Administration. FDA List of Authorized Generic Drugs: How Drugs are Developed and Approved: <http://www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/approvalapplications/abbreviatednewdrugapplicationandagenerics/ucm126389.htm>
6. U.S. Food and Drug Administration. Generic Drugs Questions and Answers: <http://www.fda.gov/Drugs/ResourcesForYou/Consumers/QuestionsAnswers/ucm100100.htm>

Revision Details

Summary of Changes	Review Date	Effective Date
<p>Removed Aciphex, Altace, Avapro, Cozaar, Fanapt, and Zestril from the policy, effective 1/1/2025.</p> <p>Added mirabegron ER (generic for Myrbetriq) as a step 1 medication, effective 1/1/2025.</p>	10/10/2024	11/15/2024
<p>Clarified the current Anti-Parkinsonism Drugs step therapy requirements apply to Monoamine Oxidase Type B (MAO-B) Inhibitors.</p> <p>Added new step therapy requirements for the following Carbidopa and Levodopa Products, Crexont and Rytary.</p>	12/12/2024	01/15/2025
<p>Removed Benicar, Benicar HCT, Celebrex, Diovan, Diovan HCT, Spriva Handihaler, and Vytorin from the policy, effective 7/1/2025.</p> <p>Added a new Ophthalmic Corticosteroids section, with Inveltys 1% ophthalmic suspension, Lotemax 0.5% ophthalmic ointment, and Lotemax SM 0.28% ophthalmic gel, effective 7/1/2025.</p> <p>Added Zoryve 0.15% cream, as a Step 3 Medication, to the Non-Steroidal Topical section.</p>	03/30/2025	05/15/2025
<p>Added Fluticasone furoate (generic for Arnuity Ellipta) as a Step Three Inhaled Corticosteroid (ICS) Medication</p> <p>Added an exception to the Inhaled Corticosteroid (ICS) step therapy requirements for a patient who is pregnant and is currently receiving the requested product for asthma.</p>	09/18/2025	11/01/2025
<p>Added Auvelity as an Antidepressant Step 3 Medication.</p> <p>Removed Actonel, Adderall, Avalide, Evekeo, Fetzima, Hyzaar, Invega, Micardis, Prevacid and Protonix from Step 3 Medications.</p>	11/06/2025	01/01/2026
<p>Updated the Auvelity requirement.</p> <p>Removed Prozac Weekly and Sarafem.</p>	02/12/2026	03/01/2026
<p>Removed the Non-Steroidal Topical therapeutic category and relocated to a new policy, <i>Topical Agents for Atopic Dermatitis Step Therapy Policy</i> (ST005).</p>	02/26/2026	04/01/2026

<p>Removed the Overactive Bladder therapeutic category, effective 5/1/2026, and relocated to a new policy, <i>Overactive Bladder Medications Step Therapy Policy</i> (ST002).</p> <p>Removed the Anti-Parkinsonism Drugs (Carbidopa and Levodopa Products) section effective 4/15/2026 and relocated to a new policy, <i>Parkinson's Disease – Carbidopa-Levodopa (Oral) Step Therapy Policy for Employer Plans</i> (ST006).</p>		
<p>Updated the Jornay PM requirement, decreasing from a quadruple step to a single step.</p>	03/26/2026	05/01/2026

The policy effective date is in force until updated or retired.

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