GENERIC STEP THERAPY PLANS (GSTP)

DRUG CLASS **PROTON PUMP INHIBITORS (PPIs)**

PGST SSB – Ref# 373-D: Prilosec Packets, Protonix Packets

HPGST SSB – Ref# 407-D: Dexilant, Prilosec Packets, Protonix Packets

TGST SSB – Ref# 383-D: Dexilant, Prilosec Packets, Protonix Packets

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 proton pump inhibitor drug within the past 180 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 system 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

Branded PPIs will be covered with post step therapy prior authorization when the following criteria are met:

- Patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one generic PPI drug.

RATIONALE

If the patient has filled a prescription for at least a 30 day supply of a generic proton pump inhibitor drug within the past 180 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 to or a potential drug interaction with a 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 one of the generic drugs for at least 30 days and had an inadequate treatment response, or requires a dosage form that is not available generically, 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
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External Review:	05/2009, 10/2009, 02/2010, 12/2010, 02/2012, 12/2012, 12/2013, 12/2014, 12/2015, 12/2016, 12/2017

CRITERIA FOR APPROVAL

1	Has the patient demonstrated an inadequate treatment response after at least a 30 day trial of at least one generic PPI? [If yes, then no further questions.]	Yes	No
2	Does the patient have a documented contraindication to or a potential drug interaction (e.g., omeprazole and Plavix) with at least one generic PPI? [If yes, then no further questions.]	Yes	No
3	Has the patient had a trial and was intolerant to at least one generic PPI? [If yes, then no further questions.]	Yes	No
4	Does the patient require use of a specific dosage form (e.g., suspension, solution) that is not available as a generic PPI?	Yes	No

Guidelines for Approval							
Duration of Approval				24 Months			
Set 1 - Failed Trial		Set 2 – Contraindication		Set 3 – Intolerant		Set 4 – Dosage Form	
Yes to question(s)	No to question(s)	Yes to question(s)	No to question(s)	Yes to question(s)	No to question(s)	Yes to question(s)	No to question(s)
1	None	2	1	3	1	4	1
					2		2
							3

Mapping Instructions		
	Yes	No
1.	Approve for 24 months	Go to 2
2.	Approve for 24 months	Go to 3
3.	Approve for 24 months	Go to 4
4.	Approve for 24 months	Deny