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Medical Benefit Step Therapy Drug List

Certain prescription drugs administered by a health care provider in a clinical or professional setting are subject to step therapy requirements, as **determined by your TRS ActiveCare medical health plan and listed in policy ADMIL23EX001**. Step therapy is a health plan coverage requirement that requires the use of one or more specified drugs before coverage is available for certain other drugs.

This list identifies the **medical pharmacy products that are not covered under the TRS ActiveCare medical health plan unless the applicable step therapy requirements are met**. These are health plan coverage rules and **do not determine coverage of the drugs** themselves.

The drugs on this list only apply to your medical health plan's step therapy requirements. Your plan has reviewed these drugs and defined those coverage requirements. This list is subject to change.

If you and your provider decide you need to get one or more of these drugs, your provider should submit a **step therapy medical benefit coverage exception request**. The request must follow your health plan's coverage rules. You may still need prior authorization, or pre-approval.

Non-Covered Product	Coverage Exception Conditions
Skyrizi® for treatment of Crohn's Disease and Ulcerative Colitis	Coverage may be allowed when **ALL of the following criteria are satisfied and supported by documentation:** **1. Inadequate Response of Conventional Inflammatory Bowel Disease (IBD) Therapy** The participant has a history of inadequate response to **at least one conventional therapy,** at maximally indicated doses unless contraindicated or not tolerated, including: • Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) • 6-mercaptopurine • Azathioprine • Methotrexate
	2. Biologic Failure, Inadequate Response or Ineligibility for Key Biologic Therapies The Participant **must meet ONE of the following**:

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Non-Covered Product	Coverage Exception Conditions
Skyrizi® for treatment of Crohn's Disease and Ulcerative Colitis (continued)	**A. Required Biologic Failure or Inadequate Response** Crohn's disease or Ulcerative Colitis: Biologic failure or inadequate response following trial ≥12 weeks of therapy with: • adalimumab **OR** infliximab **AND** • ustekinumab **B. Intolerance or Contraindication** Documented intolerance or contraindication to **BOTH**: • adalimumab **OR** infliximab **AND** • ustekinumab **3. Additional Advanced Therapy Requirement** The Participant **must also meet ONE of the following, based on medical diagnosis**: **Crohn's Disease** • Inadequate response following trial ≥ 12 weeks of therapy, or documented intolerance or contraindication, with Entyvio® (vedolizumab) **Ulcerative Colitis** Inadequate response following trial ≥12 weeks of therapy, or documented intolerance or contraindication, with: • Entyvio® (vedolizumab) **AND** • tofacitinib
Tremfya® for treatment of Crohn's Disease and Ulcerative Colitis	Coverage may be allowed when **ALL of the following criteria are satisfied and supported by documentation**: **1. Inadequate Response of Conventional IBD Therapy** The participant has a history of inadequate response to **at least one conventional therapy,** at maximally indicated doses unless contraindicated or not tolerated, including: • Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) • 6-mercaptopurine • Azathioprine • Methotrexate

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Non-Covered Product	Coverage Exception Conditions
Tremfya® for treatment of Crohn's Disease and Ulcerative Colitis (continued)	**2. Biologic Failure, Inadequate Response or Ineligibility for Key Biologic Therapies** The Participant **must meet ONE of the following**: **A. Required Biologic Failure or Inadequate Response:** Crohn's disease or Ulcerative Colitis: Biologic failure or inadequate response following trial ≥12 weeks of therapy with: • adalimumab **OR** infliximab **AND** • ustekinumab **B. Intolerance or Contraindication** Documented intolerance or contraindication to **BOTH**: • adalimumab **OR** infliximab **AND** • ustekinumab **3. Additional Advanced Therapy Requirement** The Participant **must also meet ONE of the following, based on medical diagnosis**: **Crohn's Disease** • Inadequate response following trial ≥12 weeks of therapy, or documented intolerance or contraindication, with Entyvio® (vedolizumab) **Ulcerative Colitis** Inadequate response following trial ≥12 weeks of therapy, or documented intolerance or contraindication, with: • Entyvio® (vedolizumab) **AND** • tofacitinib

Please Note: The medications on this drug list only apply to your medical health plan's step therapy coverage requirements. Drugs on this list do not determine coverage of the medication itself, under your health plan. The drugs may be subject to approval to determine coverage of the medication, under your health plan. Participants and their health care provider have the responsibility for checking the participant's health plan, summary plan description or contract to determine if there are any exclusions or other health plan limits that may apply to this service. If there are any discrepancies between this drug list and the participant's health plan materials, then the plan materials will govern.