

Step Therapy Edits

San Francisco Health Plan has Step Therapy (ST) medications listed on the Healthy Workers HMO formulary. These medications will process at the point of sale at the pharmacy if there are paid claims for the preferred medications. If there are no paid claims for the preferred medications, a prior authorization request must be submitted for consideration of coverage.

Generic Name	Brand Name	Preferred Medications
alogliptin	Nesina®	metformin containing product for at least 3 months
alogliptin-metformin	Kazano®	metformin containing product for at least 3 months
alogliptin-pioglitazone	Oseni®	metformin containing product for at least 3 months
aripiprazole	Abilify Asimtufii®, Abilify Maintena®	Prior use of any aripiprazole containing product for at least 14 days and current maintenance on any antipsychotic medication, defined as 1 fill of any antipsychotic containing product for at least 14 day-supply within last 30 days
aripiprazole lauroxil	Aristada®, Aristada Initio ER®	Current maintenance on any aripiprazole containing product for at least 14 days filled within the last 30 days
dapagliflozin	Farxiga®	Metformin, ACE, ARB, ARNI, or BB
dapagliflozin-metformin	Xigduo XR®	Metformin, ACE, ARB, ARNI, or BB
difluprednate 0.05% ophthalmic emulsion	Durezol®	prednisolone acetate 1% suspension OR prednisolone acetate 1% suspension
empagliflozin	Jardiance®	Metformin, ACE, ARB, ARNI, or BB
empagliflozin-linagliptin	Glyxambi®	Metformin, ACE, ARB, ARNI, or BB
empagliflozin-linagliptin-metformin	Trijardy® XR	Metformin, ACE, ARB, ARNI, or BB
empagliflozin-metformin, empagliflozin-metformin ER	Synjardy®, Synjardy XR®	Metformin, ACE, ARB, ARNI, or BB

Generic Name	Brand Name	Preferred Medications
emtricitabine-tenofovir alafenamide fumarate (AF)	Descovy®	emtricitabine-tenofovir disoproxil fumarate (DF)
epinastine 0.05% eye drops	Elestat®	ketotifen
eplerenone	Inspra®	spironolactone
estradiol vaginal ring	Estring®	estradiol vaginal cream or estradiol vaginal tab
estrogens, conjugated cream	Premarin®	estradiol vaginal cream or estradiol vaginal tab
eszopiclone 2 mg	Lunesta®	Prior use of 1 mg
eszopiclone 3 mg	Lunesta®	Prior use of 2 mg
fluphenazine	fluphenazine decanoate	Current maintenance on any phenothiazine containing product filled within the last 30 days
fluticasone-umeclidinium-vilanterol	Trelegy Ellipta®	Prior use of a combination of all three medication classes: long-acting muscarinic antagonist, long-acting beta agonist, and inhaled corticosteroid
haloperidol	Haldol Decanoate®	Prior use of any haloperidol containing product and current maintenance on any antipsychotic medication, defined as 1 fill of any antipsychotic containing product for at least 14 day-supply within last 30 days
insulin degludec	Tresiba®, Tresiba Flextouch®	insulin glargine, insulin glargine-yfgn, or Rezvoglar™
insulin regular, human 500 unit/mL	Humulin R® 500 unit/mL Kwikpen®, vial	insulin glargine, insulin glargine-yfgn, or Rezvoglar™
levalbuterol	Xopenex®	albuterol sulfate product, nebulizer, or albuterol HFA
liraglutide	Victoza®	metformin containing product for at least 3 months
mesalamine DR	Asacol® HD	mesalamine 1.2 g

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AS OF FEBRUARY 20, 2025

Generic Name	Brand Name	Preferred Medications
metronidazole gel	Metrogel® 1%	metronidazole 0.75% gel
naratriptan	Amerge®	sumatriptan AND rizatriptan
olanzapine	Zyprexa Relprevv®	Current maintenance on any olanzapine containing product for at least 7 days filled within the last 30 days
olopatadine 0.1% eye drops	Patanol®	ketotifen
paliperidone	Erzofri®, Invega Hafyera®, Invega Sustenna®, Invega Trinza®	Prior use of any paliperidone or risperidone containing product for at least 5 day-supply and current maintenance on any antipsychotic medication, defined as 1 fill of any antipsychotic containing product for at least 14 day-supply within last 30 days. Invega Hafyera® may be filled after any Erzofri®, Invega Sustenna®, or Invega Trinza® product have been used
patiromer	Veltassa®	Lokelma®
prednisolone acetate 0.12% eye drops	Pred Mild®	Prednisolone AC 1%
ranolazine	Ranexa®	Trial and failure with ONE of the following: beta blocker, calcium channel blocker, or long-acting nitrate
rifaximin	Xifaxan®	lactulose
risperidone	Perseris®, Uzedly®	Current maintenance on any olanzapine containing product for at least 7 days filled within the last 30 days
risperidone	Risperdal Consta®, Rykindo®	Prior use of any risperidone containing product for at least 7 days and current maintenance on any antipsychotic medication, defined as 1 fill of any antipsychotic containing product for at least 7 day-supply within last 30 days

Generic Name	Brand Name	Preferred Medications
semaglutide	Ozempic®, Rybelsus®	metformin containing product for at least 3 months
solifenacin	Vesicare®	oxybutynin
tacrolimus	Protopic®	1 medium to high potency topical steroid
tirzepatide	Mounjaro®	metformin containing product for at least 3 months
tobramycin-dexamethasone	Tobradex®	neomycin-bacitracin-polymyxin B-hydrocortisone OR neomycin-polymyxin B-dexamethasone ointment
tolterodine, tolterodine ER	Detrol®, Detrol LA®	oxybutynin
tropium, tropium ER	Sanctura®, Sanctura XR®	oxybutynin
zolpidem 10 mg	Ambien®	Prior use of 5 mg for initial dose (female patients only)
zolpidem CR	Ambien CR®	Trial and failure of at least 2 of the formulary alternatives, including zolpidem IR: eszopiclone, zaleplon, temazepam

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