Clinical Policy: California Exception to Step Through Requirements

Reference Number: HNCA.CP.PHAR.83
Effective Date: 09.01.2026
Last Review Date: 08.11.2026
Line of Business: Commercial and HIM

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy provides California expectations (Section 1367.206) for reviewing requested exceptions to criteria requiring a step through other drugs/therapies.

- This policy applies to all California Commercial (including Marketplace/Exchange) drugs with criteria requiring a step through other drugs/therapies and should be **reviewed alongside any drug-specific criteria or formulary exception criteria** for the requested medication.

FDA Approved Indication(s)

Various

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that the following drugs are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. California Step Therapy Exception Requests (must meet 1 or 2):

1. Drugs listed in the table below (*from CP.CPA.83_STEP_Therapy)* may be approved for members who have had a previous trial of the required step-through agents, when the request does not exceed the maximum indicated dose and stated quantity limit.

Drug Name	Required Step Through Agents	Maximum Dose (Quantity Limit)
aliskiren/HCTZ (Tekturna HCT®)	Generic or preferred ARB (e.g., olmesartan, olmesartan/hctz, irbesartan, losartan, candesartan, telmisartan, valsartan)	Tekturna HCT: 300/25 mg/day
Astagraf XL® (tacrolimus SR)	Generic tacrolimus	0.2 mg/kg/day
Aptiom® (eslicarbazepine)	Carbamazepine or oxcarbazepine	1,600 mg daily (2 tablets/day)

Bepreve® (bepotastine)	Generic ophthalmic olopatadine, and either azelastine or epinastine	2 drops/eye/day (0.34 mL/day)
calcipotriene-betamethasone ointment (Taclonex®)	Generic topical steroid and either topical calcitriol or calcipotriene cream	100 g/week (2 g/day)
calcipotriene-betamethasone suspension (Taclonex®)	Generic topical clobetasol and topical fluocinolone	100 g/week (2 g/day)
Celecoxib (Celebrex®)* *Applies to Oregon Commercial ONLY; for California Commercial refer to CP.PMN.122	One of the following (a, b, c, or d), unless member is > 65 years old, has prior gastrointestinal bleed, or active peptic ulcer disease (not gastroesophageal reflux disease [GERD]): a) Meloxicam; b) Generic NSAID; c) Current use of a corticosteroid; d) Current use of an anticoagulant or antiplatelet (e.g., aspirin, warfarin, low molecular weight heparin, direct thrombin inhibitors, factor Xa inhibitors, clopidogrel).	800 mg/day (2 capsules)
clonidine extended release (Nexiclon™ XR)	Generic clonidine hydrochloride immediate release	0.52 mg/day
Fluoxetine (Prozac®)	Two generic antidepressants	80 mg/day
flurandrenolide lotion 0.05% (Cordran®))	Generic topical corticosteroid alternatives	3 applications topically per day
desoximetasone spray 0.25% (Topicort®)	Generic desoximetasone 0.25% ointment or cream	Not applicable
doxycycline monohydrate	Doxycycline Hyclate	Not applicable
ethacrynic acid (Edecrin®)	Generic bumetanide, furosemide, or torsemide	400 mg/day
Fetzima® (levomilnacipran)	Two generic antidepressants	120 mg/day (20 mg: 2 tablets/day; Other strengths: 1 tablet/day)
bupropion hydrochloride ER (Forfivo XL®)	Two generic antidepressants	450 mg/day (1 tablet/day)
Lastacaft® (alcaftadine ophthalmic solution 0.25%)	Both of the following (a and b): a) Patanol or Pataday b) Azelastine or Epinastine	(1 drop/eye/day) 1 bottle/month

modafinil (Provigil®)	armodafinil (Nuvigil®)	200 mg/day for shift work disorder; 400 mg for all other indications
Oxtellar XR® (oxcarbazepine SR 150 mg, 300 mg, 600 mg)	Generic Trileptal	2,400 mg/day
pregabalin immediate-release (Lyrica®)	Both of the following (a and b): a) gabapentin b) One of the following: antidepressant, anticonvulsant, buspirone, or cyclobenzaprine	Varies
Retin-A Micro® (tretinoin microsphere gel)	Generic tretinoin product	Once daily application
Trintellix® (vortioxetine)	Two generic antidepressants	20 mg/day
Ubrelvy™ (ubrogepant)* *Ubrelvy should not be prescribed concurrently with other CGRP inhibitors (e.g., Aimovig™, Ajovy™, Emgality™, Nurtec® ODT, Qulipta™, Vyepti™)	For California Exchange Plans only: One 5HT1B/1D-agonist migraine medication (e.g., sumatriptan, rizatriptan, zolmitriptan) For California & Oregon Commercial formularies: Two 5HT1B/1D-agonist migraine medications (e.g., sumatriptan, rizatriptan, zolmitriptan)	Varies
Xhance® (fluticasone propionate)*	One formulary intranasal steroid (e.g., fluticasone propionate, mometasone, budesonide, triamcinolone)	Varies

Agents are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

2. Approve an exception if the prescribing provider submits justification showing that the required step-through drug(s) is/are inconsistent with good professional practice for that member. This applies to drug-specific, step therapy or non-formulary exception criteria for the drug under review (may be stated as either "Try a certain number of drugs" or "Try all specific alternatives") - **(must meet a and b):**
    a. Submission must include all the following (i and ii)~~:~~:
        i. A provider statement/attestation explaining the clinical rationale why therapy with the required alternative(s) would be inconsistent with good professional practice for the member.

ii. Supporting clinical documentation (chart notes, med history, labs, etc.) that backs up the rationale — and ties to the member's specific history and needs.

b. One of the four criteria below needs to be met for each required step through drugs:

i. Harm / Contraindication: The required drug is contraindicated, or is likely/expected to cause an adverse reaction or physical/mental harm vs. the requested drug

ii. Ineffective or Not Clinically Appropriate: The required drug is expected to be ineffective or is not clinically appropriate for this member and the clinical reasoning to support this.

iii. Tried and Failed: The member already tried the required drug, and it was stopped for lack of efficacy, diminished effect, or adverse reaction

iv. Stable on current drug: The member is stable on the drug the provider selected for the condition under review.

Approval duration: 12 months or duration of request, whichever is less

II. Continued Therapy

A. Step Therapy (must meet all):

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations
2. If request is for a dose increase, new dose does not exceed the FDA-approved maximum recommended dose and quantity limit as stated in the initial approval criteria for the relevant drug.

Approval duration: 12 months or duration of request, whichever is less

III. Appendices/General Information

A. This policy does not prohibit the Health Plan or a utilization review organization from requiring an enrollee to try an AB-rated generic equivalent, a biosimilar, or an interchangeable biological product before providing coverage for the equivalent branded prescription drug; this requirement does not prohibit or supersede a step therapy exception request as described in paragraph (b) above.

B. This section does not require or authorize coverage for prescription drugs that are not otherwise required under the applicable program or contract, nor does it limit or exclude any prescription drugs required by those programs or contracts.

C. Denial notices shall include a clear and concise explanation of the specific clinical reasons for the decision based on the enrollee's individual medical condition and shall inform the enrollee of applicable appeal and independent review rights.

VI. References

1. California Health and Safety Code § 1367.206 (Step Therapy Exceptions). (Amended by Stats. 2023, Ch. 495, Sec. 1. (SB 621) Effective January 1, 2024.)
2. California Health and Safety Code § 1367.241 (Prior authorization/step therapy request time limits).
3. California Health and Safety Code § 1368 (Enrollee grievance process).

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Created California Commercial line-of-business version of CP.CPA.83. Incorporated California step therapy exception requirements under Health & Safety Code § 1367.206 (SB 621) and § 1367.241 (new Section I.B). Removed Oregon-only celecoxib step therapy entry and Oregon references (California Commercial refers to CP.PMN.122). Updated line of business and description to California Commercial. Added § 1367.206, § 1367.241, and § 1368 references.	08.06.26	08.11.2026

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.