

Brand Name: ACTOplus met
Generic Name: Pioglitazone / Metformin

ActoPlus Met (pioglitazone/metformin) Step Therapy Criteria:

- Coverage is provided for a diagnosis of type 2 diabetic mellitus.
- Coverage provided for the treatment if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)

Brand Name: Actos
Generic Name: Pioglitazone HCl

Actos (pioglitazone) Step Therapy Criteria:

- Coverage is provided for a diagnosis of type 2 diabetic mellitus.
- Coverage provided for the treatment if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)

Brand Name: Avandamet
Generic Name: Rosiglitazone/Metformin HCl

Avandamet (rosiglitazone/metformin) Step Therapy Criteria:

- Coverage is provided for a diagnosis of type 2 diabetic mellitus.
- Coverage provided for the treatment if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)

Brand Name: Avandaryl
Generic Name: Rosiglitazone/Glimepiride

Avandaryl (rosiglitazone/glimepiride) Step Therapy Criteria:

- Coverage is provided for a diagnosis of type 2 diabetic mellitus.
- Coverage provided for the treatment if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)

Brand Name: Avandia
Generic Name: Rosiglitazone Maleate

Avandia (rosiglitazone) Step Therapy Criteria:

- Coverage is provided for a diagnosis of type 2 diabetic mellitus.
- Coverage provided for the treatment if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)

Brand Name: Cymbalta
Generic Name: Duloxetine HCl

Cymbalta (duloxetine) Step Therapy Criteria:

- Coverage is provided for a diagnosis of diabetic peripheral neuropathy, fibromyalgia, chronic low back pain, and chronic osteoarthritis pain.
- Coverage provided for the treatment of major depressive disorder and generalized anxiety disorder if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following generic antidepressants:
 - Fluoxetine
 - Paroxetine
 - Citalopram
 - Sertraline

Brand Name: Duetact
Generic Name: Pioglitazone/Glimepiride

Duetact (pioglitazone/glimepiride) Step Therapy Criteria:

- Coverage is provided for a diagnosis of type 2 diabetic mellitus.
- Coverage provided for the treatment if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)

Brand Name: Janumet
Generic Name: Sitagliptin phos / metformin

Janumet (sitagliptin/metformin) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetes mellitus.
- Coverage is provided for the treatment of type 2 diabetes mellitus if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Benefit is provided for 12 months.

Brand Name: Januvia
Generic Name: Sitagliptin Phosphate

Januvia (sitagliptin) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetes mellitus.
- Coverage is provided for the treatment of type 2 diabetes mellitus if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
 - Glucophage (Metformin)
 - Glucophage XR (Metformin ER)
 - Glucovance (metformin/glyburide)
 - Metaglip (metformin/glipizide)
 - Glumetza (metformin)
 - Riomet (metformin)
 - Fortamet (metformin)
 - Amaryl (glimepiride)
 - DiaBeta, Glynase, Micronase (glyburide)
 - Diabinese (chlorpropamide)
 - Glucotrol, Glucotrol XL (glipizide)
 - Orinase (tolbutamide)
 - Tolinase (tolazamide)
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Benefit is provided for 12 months.

Brand Name: Lipitor
Generic Name: Atorvastatin

- Benefit is approved in instances when the patient has tried and failed a generic formulary alternative or in instances when the physician can provide documentation of an intolerance or adverse event to one of the alternatives and an explanation as to why they are trying another medication in the same class.
- Benefit is approved for 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Restasis
Generic Name: Cyclosporine

Restasis (cyclosporine ophthalmic emulsion) Step Therapy Criteria:

- Benefit is approved to increase tear production, when tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca.
- Benefit is approved after patient has tried and failed treatment with Tears Naturale, Artificial Tears, Refresh, Genteal, Lacrilube, Celluvisc, or Bion Tears, or has required other treatments such as punctal plugs or goggles.
- Member must be 16 years of age or older
- Benefit is approved for 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.