

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 in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
- In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
- 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: **Actos**
Generic Name: **Pioglitazone**

Actos (pioglitazone) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetic mellitus in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
- In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
- 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: **Avandamet**
Generic Name: **Rosiglitazone/Metformin HCl**

Avandamet (rosiglitazone/metformin) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetic mellitus in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
- In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
- 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: **Avandaryl**
Generic Name: **Rosiglitazone/Glimepiride**

Avandaryl (rosiglitazone/glimepiride) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetic mellitus in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
- In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
- 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: **Avandia**
Generic Name: **Rosiglitazone Maleate**

Avandia (rosiglitazone) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetic mellitus in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
- In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
- 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: **Azor**

Generic Name: **Amlodipine / Olmesartan**

Azor (amlodipine/olmesartan) Step Therapy Criteria

- Coverage provided if the member has had an inadequate response or intolerance to one ACE Inhibitor (lisinopril, quinapril, benzapril, etc) in the past 6 months.
- Benefit coverage for situations in which none of the above qualifications exist in the claims history is determined through the exception review process
- 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: **Benicar**

Generic Name: **Olmesartan Medoxomil**

Benicar (olmesartan) Step Therapy Criteria

- Coverage provided if the member has had an inadequate response or intolerance to one ACE Inhibitor (lisinopril, quinapril, benzapril, etc) in the past 6 months.
- Benefit coverage for situations in which none of the above qualifications exist in the claims history is determined through the exception review process
- 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: **Benicar HCT**

Generic Name: **Olmesartan Medoxomil/HCTZ**

Benicar HCT (olmesartan/hydrochlorothiazide) Step Therapy Criteria

- Coverage provided if the member has had an inadequate response or intolerance to one ACE Inhibitor (lisinopril, quinapril, benzapril, etc) in the past 6 months.
- Benefit coverage for situations in which none of the above qualifications exist in the claims history is determined through the exception review process
- 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: **Cymbalta**

Generic Name: **Duloxetine**

Cymbalta (duloxetine) Step Therapy Criteria

- Coverage is provided for a diagnosis of diabetic peripheral neuropathy.
- Coverage is provided for a diagnosis of fibromyalgia if the patient has a prescription in the claim history during the previous 180 days for Lyrica or a tricyclic antidepressant (amitriptyline or nortriptyline).
- Coverage provided for the treatment of major depressive disorder and generalized anxiety disorder in situations where there is a prescription in claim history during the previous 180 days for any of the following:
 - citalopram
 - fluoxetine
 - fluvoxamine
 - paroxetine
 - sertraline
 - venlafaxine IR
- Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review

process.

- Benefit duration is 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: **Diovan**

Generic Name: **Valsartan**

Diovan (valsartan) Step Therapy Criteria

- Coverage provided if the member has had an inadequate response or intolerance to one ACE Inhibitor (lisinopril, quinapril, benzapril, etc) in the past 6 months.
- Benefit coverage for situations in which none of the above qualifications exist in the claims history is determined through the exception review process.
- 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: **Diovan HCT**

Generic Name: **Valsartan/Hydrochlorothiazide**

Diovan HCT (valsartan/hydrochlorothiazide) Step Therapy Criteria

- Coverage provided if the member has had an inadequate response or intolerance to one ACE Inhibitor (lisinopril, quinapril, benzapril, etc) in the past 6 months.
- Benefit coverage for situations in which none of the above qualifications exist in the claims history is determined through the exception review process.
- 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: **Duetact**

Generic Name: **Pioglitazone / Glimepiride**

Duetact (pioglitazone/glimepiride) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetic mellitus in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
- In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
- 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: **Effexor XR**

Generic Name: **Venlafaxine HCl XR**

Effexor XR (venlafaxine) Step Therapy Criteria

- Coverage provided for the treatment of major depressive disorder, generalized anxiety disorder, panic disorder, and social anxiety disorder in situations where there is a prescription in claim history during the previous 180 days for any of the following:
 - citalopram
 - fluoxetine
 - fluvoxamine
 - paroxetine
 - sertraline
 - venlafaxine IR
- Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
- Benefit duration is 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: **Emsam**

Generic Name: **Selegiline**

Emsam (selegiline) Transdermal System Step Therapy Criteria

- Coverage provided for the treatment of major depressive disorder in situations where there is a prescription in claim history during the previous 180 days for any of the following:
 - citalopram
 - fluoxetine
 - fluvoxamine
 - paroxetine
 - sertraline
 - venlafaxine IR
- Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
- Benefit duration is 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: **Exforge**

Generic Name: **Amlodipine / Valsartan**

Exforge (amlodipine/valsartan) Step Therapy Criteria

- Coverage provided if the member has had an inadequate response or intolerance to one ACE Inhibitor (lisinopril, quinapril, benzapril, etc) in the past 6 months.
- Benefit coverage for situations in which none of the above qualifications exist in the claims history is determined through the exception review process.
- Benefit duration is 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: **Exforge HCT**

Generic Name: **Amlodipine / Valsartan / HCTZ**

Exforge HCT(amlodipine/valsartan/hydrochlorothiazide) Step Therapy Criteria

- Coverage provided if the member has had an inadequate response or intolerance to one ACE Inhibitor (lisinopril, quinapril, benzapril, etc) in the past 6 months.
- Benefit coverage for situations in which none of the above qualifications exist in the claims history is determined through the exception review process.
- Benefit duration is 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: **Janumet**

Generic Name: **Sitagliptin/Metformin**

Janumet (sitagliptin/metformin) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetic mellitus in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
 - In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
 - 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: **Januvia**

Generic Name: **Sitagliptin**

Januvia (sitagliptin) Step Therapy Criteria

- Coverage is provided for a diagnosis of type 2 diabetic mellitus in patients whose blood glucose is not adequately controlled on metformin or a sulfonyurea.
- Coverage provided for the treatment if the member has tried and failed or had an intolerance to metformin or a sulfonyurea in the past 6 months:
 - In situations where none of the above exists in claim history, coverage is determined through the exceptions coverage process.
 - 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: **Lexapro**

Generic Name: **Escitalopram Oxalate**

Lexapro (escitalopram) Step Therapy Criteria

- Coverage provided for the treatment of major depressive disorder and generalized anxiety disorder in situations where there is a prescription in claim history during the previous 180 days for any of the following:
 - citalopram
 - fluoxetine
 - fluvoxamine
 - paroxetine
 - sertraline
 - venlafaxine IR
- Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
- Benefit duration is 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: **Prevacid**

Generic Name: **Lansoprazole**

Prevacid (lansoprazole) Step Therapy Criteria

- Benefit coverage is provided immediately for lansoprazole (generic Prevacid) in situations where paid claims for prescription strength omeprazole in claim history during the previous 6 months.
- In situations where none of the above exists in claim history, coverage is determined through the exceptions review process.
- Benefit duration is 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: **Pristiq**

Generic Name: **Desvenlafaxine Succinate**

Pristiq (desvenlafaxine) Step Therapy Criteria

- Coverage for Pristiq if the member has a prescription in their claim history during the previous 180 days for any of the following:
 - Cymbalta
 - Effexor XR
- Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
- Benefit duration is 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: **Zetia**

Generic Name: **Ezetimibe**

Zetia (ezetimibe) Step Therapy Criteria

- Zetia is provided for the treatment of dyslipidemia in patients whose cholesterol is not adequately controlled on a HMG-COA reductase inhibitor (simvastatin, lovastatin, pravastatin, Lipitor, Crestor) alone or in patients who have an intolerance or contraindication to a HMG-COA reductase inhibitor.
- Coverage is provided for Zetia in situations where the patient has paid claims history during the prior 6 months for a HMG-COA reductase inhibitor (simvastatin, lovastatin, pravastatin).
- Benefit coverage for situations in which none of the above qualifications exist in history is determined through the exception review process.
- Benefit duration is 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.