

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 or had intolerance to metformin or a sulfonyurea (determined by pharmacy claims review or through the exception review process).
- Coverage is provided for 12 months.

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 or had intolerance to metformin or a sulfonyurea (determined by pharmacy claims review or through the exceptions review process).
- Coverage is provided for 12 months.

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 or had intolerance to metformin or a sulfonyurea (determined by pharmacy claims review or through the exceptions review process).
- Coverage is provided for 12 months.

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 or had intolerance to metformin or a sulfonyurea (determined by pharmacy claims review or through the exceptions review process).
- Coverage is provided for 12 months.

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 or had intolerance to metformin or a sulfonyurea (determined by pharmacy claims review or through the exceptions review process).
- Coverage is provided for 12 months.

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 or had intolerance to metformin or a sulfonyurea (determined by pharmacy claims review or through the exceptions review process).
- Coverage is provided for 12 months.

Brand Name: Janumet
Generic Name: Sitagliptin/Metformin

Janumet (sitagliptin/metformin) Step Therapy Criteria

- Coverage is provided for members with a diagnosis of type 2 diabetic mellitus whose blood glucose is not adequately controlled on metformin or a sulfonyurea (determined by pharmacy claims review or through the exceptions review process).
- Coverage is provided for 12 months.

Brand Name: Januvia
Generic Name: Sitagliptin

Januvia (sitagliptin) Step Therapy Criteria

- Coverage is provided for members with a diagnosis of type 2 diabetic mellitus whose blood glucose is not adequately controlled on metformin or a sulfonyurea (determined by pharmacy claims review or through the exceptions review process).
- Coverage is provided for 12 months.

Brand Name: Pristiq
Generic Name: Desvenlafaxine Succinate

Pristiq (desvenlafaxine) Step Therapy Criteria

- Coverage is provided for the treatment of major depressive disorder if the member had an inadequate response or intolerance to Cymbalta or venlafaxine ER (generic Effexor XR) determined by pharmacy claims review or through the exceptions review process.
- Coverage is provided for 12 months.

Brand Name: Zetia
Generic Name: Ezetimibe

Zetia (ezetimibe) Step Therapy Criteria

- Zetia is provided for the treatment of dyslipidemia if the member had an inadequate response or intolerance to simvastatin (generic Zocor), lovastatin (generic Mevacor), pravastatin (generic Pravachol) determined by pharmacy claims review or through the exceptions review process.
- Coverage is provided for 12 months.