STEP THERAPY PROGRAMS

How do I request an exception to the Ultimate Health Plans' Formulary?

You can ask Ultimate Health Plans to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Ultimate Health Plans limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. "Also, you may not ask us to provide a higher level of coverage for drugs that are in the specialty tier."

Generally, Ultimate Health Plans will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

Your physician must submit a statement supporting your coverage determination or exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

What if I have additional questions?
You can call us at: 1-800-546-5677 (seven days a week, 24 hours a day) if you have any additional questions. If you have a hearing or speech impairment, please call us at TTY 1-866-706-4757.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: APLENZIN TAB174MG

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: APLENZIN TAB348MG

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: APLENZIN TAB522MG

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: DESVENLAFAX TAB100MG ER

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: DESVENLAFAX TAB50MG ER

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: EMSAM DIS12MG/24H

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: EMSAM DIS6MG/24HR

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: EMSAM DIS9MG/24HR

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FANAPT PAK

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FANAPT TAB10MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: FANAPT TAB12MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FANAPT TAB1MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FANAPT TAB2MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FANAPT TAB4MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: FANAPT TAB6MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FANAPT TAB8MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FETZIMA CAP120MG

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FETZIMA CAP20MG

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: FETZIMA CAP40MG

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FETZIMA CAP80MG

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: FETZIMA CAPTITRATIO

CRITERIA: Aplenzin, Desvenlafaxine er, Emsam, and Fetzima shall be considered medically necessary for members who have had an adequate trial of two, one month therapies on the following therapy: bupropion, bupropion sr, bupropion xl, citalopram, desvenlafaxine er, duloxetine, escitalopram, fluoxetine, fluvoxamine, fluvoxamine er, mirtazapine, mirtazapine odt, paroxetine, paroxetine er, sertraline, venlafaxine, or venlafaxine er within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: GRANIX INJ300/0.5

CRITERIA: Granix shall be considered medically necessary for members who have had an adequate trial of one month of therapy on Zarxio within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: GRANIX INJ480/0.8

CRITERIA: Granix shall be considered medically necessary for members who have had an adequate trial of one month of therapy on Zarxio within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET TAB150-1000

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET TAB150-500

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET TAB50-1000

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET TAB50-500MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET XRTAB150-1000

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET XRTAB150-500

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET XRTAB50-1000

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: INVOKAMET XRTAB50-500MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKANA TAB100MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: INVOKANA TAB300MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JANUMET TAB50-1000

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: JANUMET TAB50-500MG

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JANUMET XR TAB100-1000

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JANUMET XR TAB50-1000

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JANUMET XR TAB50-500MG

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: JANUVIA TAB100MG

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JANUVIA TAB25MG

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JANUVIA TAB50MG

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JARDIANCE TAB10MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: JARDIANCE TAB25MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JENTADUETO TAB2.5-1000

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JENTADUETO TAB2.5-500

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JENTADUETO TAB2.5-850

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: JENTADUETO TABXR2.5-1000

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: JENTADUETO TABXR5-1000

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: LIVALO TAB1MG

CRITERIA: Livalo shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: atorvastatin, fluvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, or simvastatin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: LIVALO TAB2MG

CRITERIA: Livalo shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: atorvastatin, fluvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, or simvastatin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: LIVALO TAB4MG

CRITERIA: Livalo shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: atorvastatin, fluvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, or simvastatin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: NEUPRO DIS1MG/24HR

CRITERIA: Neupro shall be considered medically necessary for members who have had an adequate trial of one month of therapy on the following therapy: pramipexole, pramipexole er, ropinirole, or ropinirole er within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: NEUPRO DIS2MG/24HR

CRITERIA: Neupro shall be considered medically necessary for members who have had an adequate trial of one month of therapy on the following therapy: pramipexole, pramipexole er, ropinirole, or ropinirole er within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: NEUPRO DIS3MG/24HR

CRITERIA: Neupro shall be considered medically necessary for members who have had an adequate trial of one month of therapy on the following therapy: pramipexole, pramipexole er, ropinirole, or ropinirole er within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: NEUPRO DIS4MG/24HR

CRITERIA: Neupro shall be considered medically necessary for members who have had an adequate trial of one month of therapy on the following therapy: pramipexole, pramipexole er, ropinirole, or ropinirole er within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: NEUPRO DIS6MG/24HR

CRITERIA: Neupro shall be considered medically necessary for members who have had an adequate trial of one month of therapy on the following therapy: pramipexole, pramipexole er, ropinirole, or ropinirole er within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: NEUPRO DIS8MG/24HR

CRITERIA: Neupro shall be considered medically necessary for members who have had an adequate trial of one month of therapy on the following therapy: pramipexole, pramipexole er, ropinirole, or ropinirole er within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: RYTARY CAP145MG

CRITERIA: Rytary shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: amantadine, carbidopa/levodopa, carbidopa/levodopa er, carbidopa, entacapone, pramipexole, pramipexole er, ropinirole, ropinirole er, selegiline, or tolcapone within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: RYTARY CAP195MG

CRITERIA: Rytary shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: amantadine, carbidopa/levodopa, carbidopa/levodopa er, carbidopa, entacapone, pramipexole, pramipexole er, ropinirole, ropinirole er, selegiline, or tolcapone within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: RYTARY CAP245MG

CRITERIA: Rytary shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: amantadine, carbidopa/levodopa, carbidopa/levodopa er, carbidopa, entacapone, pramipexole, pramipexole er, ropinirole, ropinirole er, selegiline, or tolcapone within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: RYTARY CAP95MG

CRITERIA: Rytary shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: amantadine, carbidopa/levodopa, carbidopa/levodopa er, carbidopa, entacapone, pramipexole, pramipexole er, ropinirole, ropinirole er, selegiline, or tolcapone within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: SYNJARDY TAB

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: SYNJARDY TAB12.5-500

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: SYNJARDY TAB5-1000MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: SYNJARDY TAB5-500MG

CRITERIA: Invokamet, Invokamet XR, Invokana, Jardiance, and Synjardy shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: TRADJENTA TAB5MG

CRITERIA: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, and Tradjenta shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: TRULICITY INJ0.75/0.5

CRITERIA: Trulicity and Victoza shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: TRULICITY INJ1.5/0.5

CRITERIA: Trulicity and Victoza shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: ULORIC TAB40MG

CRITERIA: Uloric shall be considered medically necessary for members who have had an adequate trial of one month of therapy on allopurinol within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: ULORIC TAB80MG

CRITERIA: Uloric shall be considered medically necessary for members who have had an adequate trial of one month of therapy on allopurinol within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: VICTOZA INJ18MG/3ML

CRITERIA: Trulicity and Victoza shall be considered medically necessary for members who have had an adequate trial of one month of therapy on one of the following therapies: glipizide/metformin, glyburide/metformin, metformin, metformin er, pioglitazone/metformin, or repaglinide/metformin within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: VRAYLAR CAP1.5-3MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: VRAYLAR CAP1.5MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: VRAYLAR CAP3MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: VRAYLAR CAP4.5MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

MEDICATION SUBJECT TO STEP THERAPY: VRAYLAR CAP6MG

CRITERIA: Fanapt and Vraylar shall be considered medically necessary for members who have had an adequate trial of one month of therapy on two of the following therapies: aripiprazole, aripiprazole odt, olanzapine, olanzapine odt, paliperidone er, quetiapine, quetiapine er, risperidone, risperidone odt, or ziprasidone within the previous 730 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.

STEP THERAPY PROGRAMS

MEDICATION SUBJECT TO STEP THERAPY: ZYFLO TAB600MG

CRITERIA: Zyflo shall be considered medically necessary for members who have had an adequate trial of one month of therapy on montelukast or zafirlukast within the previous 180 days as determined by on-line prescription drug claim history. An adequate therapeutic trial will be considered one month of therapy tried. If criteria is met, the claim for the medication subject to step therapy shall be covered. If on-line prescription claims history is not available, please contact the customer service center at 1-800-546-5677 to request coverage as a medical exception.