

DRUG NAME/CLASS	STEP THERAPY CRITERIA	Additional Limits & Specifications
<b>ANTIPSYCHOTIC THERAPY</b>		
ABILIFY	Previous use of any TWO (2) antipsychotic medications (examples: Geodon, Risperdal, Zyprexa, Seroquel)	
<b>ANGIOTENSIN II RECEPTOR BLOCKERS (ARB) THERAPY</b>		
COZAAR, HYZAAR, DIOVAN, DIOVAN HCT, MICARDIS, MICARDIS HCT	Previous use of an ACE inhibitor (examples: lisinopril, enalapril, benazepril)	
<b>ASTHMA THERAPY</b>		
SINGULAIR	Previous use of an inhaled steroid (examples: Flovent, Pulmicort, Qvar)	Allergic rhinitis is not a covered diagnosis
ADVAIR	Previous use of an inhaled steroid (examples: Flovent, Pulmicort, Qvar)	
<b>INSOMNIA THERAPY</b>		
AMBIEN, SONATA	Previous use of an established hypnotic (examples: triazolam, flurazepam)	
<b>MIGRAINE THERAPY</b>		
AXERT, IMITREX	Previous use of a migraine prophylaxis medication (examples: propranolol, verapamil, Depakote)	Maximum of 18 tablets per 30 days, or 8 kits per 30 days or 160mg nasal sprays per 30 days
MIGRANAL	Previous use of a migraine prophylaxis medication (examples: propranolol, verapamil, Depakote)	8 vials per 30 days
<b>COX II THERAPY</b>		
CELEBREX	Systematic check for age > 65, previous NSAID, PPI / H2 antagonist or warfarin / LMWH therapy within last 6 months	
<b>ADD/ADHD THERAPY</b>		
STRATTERA	Previous use of any TWO (2) long-acting ADHD medications (examples: methylphenidate ER, Adderall XR, Concerta, Metadate CD)	
<b>ANTIFUNGALS</b>		
FLUCONAZOLE	N/A	Fluconazole 150mg x 1 tab only for vaginal candidiasis

For questions related to these criteria and the prior authorization process in general, please contact Molina Salud at (888) 884-9527.