

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
Abilify

Products Affected

- abilify oral tablet

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourettes Disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourettes Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourettes Disorder AND There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Absorica

Products Affected

- absorica

PA Criteria	Criteria Details
Covered Uses	Severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member is enrolled in the FDA iPLEDGE program and, because of significant adverse reactions associated with its use, should be reserved for patients with multiple severe nodular acne who are unresponsive to conventional therapy, including topical acne products and systemic antibiotics. Treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Abstral

Products Affected

- abstral

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
QL Criteria	120 tablets Per 30 Days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Acamprosate Calcium

Products Affected

- *acamprosate calcium*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accolate

Products Affected

- accolate

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Accu-Chek Aviva Plus

Products Affected

- accu-chek aviva plus in vitro

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Compact Plus

Products Affected

- accu-chek compact plus

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Accu-Chek Multiclix Lancet Dev

Products Affected

- accu-chek multiclix lancet dev

QL Criteria	1 KIT Per 365 DAYSS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek SmartView

Products Affected

- accu-chek smartview

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Accutrend Glucose

Products Affected

- accutrend glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	150 MLS Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral tablet 300-15 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	13 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral tablet 300-60 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	10 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Acetaminophen-Codeine #2

Products Affected

- *acetaminophen-codeine #2*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	13 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Acetaminophen-Codeine #3

Products Affected

- *acetaminophen-codeine #3*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Acetaminophen-Codeine #4

Products Affected

- *acetaminophen-codeine #4*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aciphex

Products Affected

- aciphex

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AcipHex Sprinkle

Products Affected

- aciphex sprinkle

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Acitretin

Products Affected

- *acitretin*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actemra

Products Affected

- actemra intravenous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Actemra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actemra

Products Affected

- actemra subcutaneous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Actemra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 SYRINGES Per 28 DAYs
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actimmune

Products Affected

- actimmune

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/actimmune.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actiq

Products Affected

- actiq

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
QL Criteria	120 Lozenges Per 30 Days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Activella

Products Affected

- activella

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actonel

Products Affected

- actonel oral tablet 150 mg

QL Criteria	1 tablet Per 28 Days
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actonel

Products Affected

- actonel oral tablet 30 mg, 5 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actonel

Products Affected

- actonel oral tablet 35 mg

QL Criteria	4 tablets Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actoplus Met

Products Affected

- actoplus met

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actoplus met XR

Products Affected

- actoplus met xr

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Actos

Products Affected

- actos

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aczone

Products Affected

- aczone

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adagen

Products Affected

- adagen

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adalat CC

Products Affected

- adalat cc oral tablet extended release 24 hour 30 mg, 90 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adalat CC

Products Affected

- adalat cc oral tablet extended release 24 hour 60 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adapalene

Products Affected

- *adapalene external solution*

QL Criteria	2 mls Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: October 22, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adcirca

Products Affected

- adcirca

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adderall

Products Affected

- adderall

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adderall XR

Products Affected

- adderall xr

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adefovir Dipivoxil

Products Affected

- *adefovir dipivoxil*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adempas

Products Affected

- adempas

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adlyxin

Products Affected

- adlyxin

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 pens Per 28 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adlyxin Starter Pack

Products Affected

- adlyxin starter pack

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 kit Per 365 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advair Diskus

Products Affected

- advair diskus inhalation aerosol powder
breath activated 100-50 mcg/dose, 250-50
mcg/dose

QL Criteria	1 diskus Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advair Diskus

Products Affected

- advair diskus inhalation aerosol powder
breath activated 500-50 mcg/dose

QL Criteria	2 diskus Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advair HFA

Products Affected

- advair hfa

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advance Intuition Test

Products Affected

- advance intuition test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advance Micro-Draw Test

Products Affected

- advance micro-draw test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advate

Products Affected

- advate

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advocate Duo

Products Affected

- advocate duo device

QL Criteria	1 meter Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advocate Redi-Code

Products Affected

- advocate redi-code in vitro

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advocate Redi-Code+ Test

Products Affected

- advocate redi-code+ test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Advocate Test

Products Affected

- advocate test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adynovate

Products Affected

- adynovate

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Adyphren

Products Affected

- adyphren

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adyphren Amp II

Products Affected

- adyphren amp ii

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adyphren II

Products Affected

- adyphren ii

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adzenys ER

Products Affected

- adzenys er

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	15 ml Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Adzenys XR-ODT

Products Affected

- adzenys xr-odt

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Afeditab CR

Products Affected

- *afeditab cr oral tablet extended release 24 hour 30 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Afeditab CR

Products Affected

- *afeditab cr oral tablet extended release 24 hour 60 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Afinitor

Products Affected

- afinitor

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Afinitor Disperz

Products Affected

- afinitor disperz

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tabs Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Afrezza

Products Affected

- afrezza inhalation powder 12 unit, 8 unit

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin, (2) In all Patients, no history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD), and (3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Afrezza

Products Affected

- afrezza inhalation powder 4 & 8 & 12 unit,
4 (90) & 8 (90) unit, 4 unit

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin, (2) In all Patients, no history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD), and (3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: February 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Afstyla

Products Affected

- afstyla

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AgaMatrix AMP Test

Products Affected

- agamatrix amp test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AgaMatrix Jazz Test

Products Affected

- agamatrix jazz test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AgaMatrix KeyNote Test

Products Affected

- agamatrix keynote test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AgaMatrix Presto Test

Products Affected

- agamatrix presto test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aimovig

Products Affected

- aimovig

PA Criteria	Criteria Details
Covered Uses	Episodic or chronic migraines
Exclusion Criteria	
Required Medical Information	INITIAL CRITERIA: A documented diagnosis of episodic or chronic migraines characterized by four or more headaches per month and member is at least 18 years of age or older. REAUTHORIZATION CRITERIA: Additional coverage will be provided if the member has experienced 2 fewer headaches per month or there is documentation of clinical response or disease stability.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months initially, 1 year renewal if 2 fewer headaches per month
Other Criteria	
QL Criteria	2 pens Per 1 month
Notes/References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aimovig 140 Dose

Products Affected

- aimovig 140 dose

PA Criteria	Criteria Details
Covered Uses	Episodic or chronic migraines
Exclusion Criteria	
Required Medical Information	INITIAL CRITERIA: A documented diagnosis of episodic or chronic migraines characterized by four or more headaches per month and member is at least 18 years of age or older. REAUTHORIZATION CRITERIA: Additional coverage will be provided if the member has experienced 2 fewer headaches per month or there is documentation of clinical response or disease stability.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months initially, 1 year renewal if 2 fewer headaches per month
Other Criteria	
QL Criteria	2 pens Per 1 month
Notes/References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AirDuo RespiClick 113/14

Products Affected

- airduo respiclick 113/14

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AirDuo RespiClick 232/14

Products Affected

- airduo respiclick 232/14

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AirDuo RespiClick 55/14

Products Affected

- airduo respiclick 55/14

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ajovy

Products Affected

- ajovy

PA Criteria	Criteria Details
Covered Uses	Episodic or chronic migraines
Exclusion Criteria	
Required Medical Information	INITIAL CRITERIA: A documented diagnosis of episodic or chronic migraines characterized by four or more headaches per month and member is at least 18 years of age or older. REAUTHORIZATION CRITERIA: Additional coverage will be provided if the member has experienced 2 fewer headaches per month or there is documentation of clinical response or disease stability.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months initially, 1 year renewal if 2 fewer headaches per month
Other Criteria	
QL Criteria	1 injection Per 1 month
Notes/References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Akynzeo

Products Affected

- akynzeo oral

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of nausea and vomiting associated with cancer chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Akynzeo will be considered medically necessary for those members who have a documented chemotherapy regimen that requires more than two cycles of antiemetic per 30 days
QL Criteria	2 capsules Per 1 month
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Albendazole

Products Affected

- *albendazole oral*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Albenza

Products Affected

- albenza

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aldara

Products Affected

- aldara

QL Criteria	48 packets Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aldurazyme

Products Affected

- aldurazyme

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Alecensa

Products Affected

- alecensa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 10 mg, 40 mg, 5 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 35 mg*

QL Criteria	8 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 70 mg*

QL Criteria	4 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alfuzosin HCl ER

Products Affected

- *alfuzosin hcl er*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alinia

Products Affected

- alinia oral suspension reconstituted

QL Criteria	180 ML Per 3 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alinia

Products Affected

- alinia oral tablet

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Almotriptan Malate

Products Affected

- *almotriptan malate*

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alogliptin Benzoate

Products Affected

- *alogliptin benzoate*

QL Criteria	1 tablets Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alogliptin-Metformin HCl

Products Affected

- *alogliptin-metformin hcl*

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alogliptin-Pioglitazone

Products Affected

- *alogliptin-pioglitazone*

QL Criteria	1 tablets Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alora

Products Affected

- alora

QL Criteria	8 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alosetron HCl

Products Affected

- *alosetron hcl*

PA Criteria	Criteria Details
Covered Uses	Severe diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis in a female patient of severe diarrhea-predominant irritable bowel syndrome (IBS) with either frequent and severe abdominal pain/discomfort, frequent urgency or fecal incontinence, or disability or restriction of daily activities due to IBS, and the patient has chronic IBS symptoms generally lasting 6 months or longer, and anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 30, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alphanate/VWF Complex/Human

Products Affected

- alphanate/vwf complex/human

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AlphaNine SD

Products Affected

- alphanine sd

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ALPRAZolam ER

Products Affected

- *alprazolam er*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ALPRAZolam XR

Products Affected

- *alprazolam xr*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alprolix

Products Affected

- alprolix

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Altoprev

Products Affected

- altoprev

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Altreno

Products Affected

- altreno

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tube Per 1 month
Notes/References	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: November 25, 2018
----------------------	--

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alunbrig

Products Affected

- alunbrig oral tablet 180 mg, 90 mg
- alunbrig oral tablet therapy pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Alunbrig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alunbrig

Products Affected

- alunbrig oral tablet 30 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Alunbrig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Alvesco

Products Affected

- alvesco

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ambien

Products Affected

- ambien

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: December 15, 2017

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ambien CR

Products Affected

- ambien cr

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amerge

Products Affected

- amerge

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amitiza

Products Affected

- amitiza

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amlodipine Besylate-Valsartan

Products Affected

- *amlodipine besylate-valsartan*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amlodipine-Atorvastatin

Products Affected

- *amlodipine-atorvastatin*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amlodipine-Olmesartan

Products Affected

- *amlodipine-olmesartan*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amlodipine-Valsartan-HCTZ

Products Affected

- *amlodipine-valsartan-hctz*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amnesteem

Products Affected

- *amnesteem*

PA Criteria	Criteria Details
Covered Uses	Severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member is enrolled in the FDA iPLEDGE program and, because of significant adverse reactions associated with its use, should be reserved for patients with multiple severe nodular acne who are unresponsive to conventional therapy, including topical acne products and systemic antibiotics. Treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amphetamine Sulfate

Products Affected

- *amphetamine sulfate*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine*

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ampyra

Products Affected

- ampyra

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Ampyra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Androderm

Products Affected

- androderm transdermal patch 24 hour

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	1 patch Per 1 Day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AndroGel

Products Affected

- androgel transdermal gel 20.25 mg/1.25gm (1.62%), 40.5 mg/2.5gm (1.62%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	5 grams Per 1 Day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AndroGel

Products Affected

- androgel transdermal gel 25 mg/2.5gm (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	2.5 grams Per 1 Day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: November 28, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AndroGel

Products Affected

- androgel transdermal gel 50 mg/5gm (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	10 grams Per 1 Day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

AndroGel Pump

Products Affected

- androgel pump transdermal gel 20.25 mg/act (1.62%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	5 grams Per 1 Day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: November 28, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Anoro Ellipta

Products Affected

- anoro ellipta

QL Criteria	60 BLISTERS Per 30 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Antara

Products Affected

- antara oral capsule 30 mg, 90 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Anzemet

Products Affected

- anzemet oral

QL Criteria	5 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

APAP-Caff-Dihydrocodeine

Products Affected

- *apap-caff-dihydrocodeine oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

APAP-Caff-Dihydrocodeine

Products Affected

- *apap-caff-dihydrocodeine oral tablet 325-30-16 mg*

QL Criteria	10 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aplenzin

Products Affected

- aplenzin

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aprepitant

Products Affected

- *aprepitant oral capsule 125 mg, 40 mg, 80 mg*

QL Criteria	5 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aprepitant

Products Affected

- *aprepitant oral capsule 80 & 125 mg*

QL Criteria	9 capsules Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Apriso

Products Affected

- apriso

QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aptensio XR

Products Affected

- aptensio xr

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aptiom

Products Affected

- aptiom oral tablet 200 mg, 600 mg

QL Criteria	2 TABS Per 1 DAYS
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aptiom

Products Affected

- aptiom oral tablet 400 mg, 800 mg

QL Criteria	1 TABS Per 1 DAYS
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aralast NP

Products Affected

- aralast np intravenous solution
reconstituted 1000 mg, 500 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Alp ha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aranesp (Albumin Free)

Products Affected

- aranesp (albumin free) injection solution 100 mcg/ml, 200 mcg/ml, 25 mcg/ml, 300 mcg/ml, 40 mcg/ml, 60 mcg/ml prefilled syringe 100 mcg/0.5ml, 150 mcg/0.3ml, 200 mcg/0.4ml, 25 mcg/0.42ml, 300 mcg/0.6ml, 40 mcg/0.4ml, 500 mcg/ml, 60 mcg/0.3ml
- aranesp (albumin free) injection solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arava

Products Affected

- arava

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arcalyst

Products Affected

- arcalyst

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Arca
lyst.html">http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Arca lyst.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arcapta Neohaler

Products Affected

- arcapta neohaler

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aricept

Products Affected

- aricept

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ARIPiprazole

Products Affected

- *aripiprazole oral solution*

QL Criteria	30 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ARIPiprazole

Products Affected

- *aripiprazole oral tablet*
- *aripiprazole oral tablet dispersible*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arixtra

Products Affected

- arixtra

QL Criteria	30 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Armodafinil

Products Affected

- *armodafinil oral tablet 150 mg, 200 mg, 250 mg*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping.
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Armodafinil

Products Affected

- *armodafinil oral tablet 50 mg*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping.
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ArmonAir RespiClick 113

Products Affected

- armonair respiclick 113

PA Criteria	Criteria Details
Covered Uses	Maintenance treatment of asthma as prophylactic therapy in patients 12 years of age and older.
Exclusion Criteria	Not indicated for the relief of acute bronchospasm
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicated disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ArmonAir RespiClick 232

Products Affected

- armonair respiclick 232

PA Criteria	Criteria Details
Covered Uses	Maintenance treatment of asthma as prophylactic therapy in patients 12 years of age and older.
Exclusion Criteria	Not indicated for the relief of acute bronchospasm
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicated disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ArmonAir RespiClick 55

Products Affected

- armonair respiclick 55

PA Criteria	Criteria Details
Covered Uses	Maintenance treatment of asthma as prophylactic therapy in patients 12 years of age and older.
Exclusion Criteria	Not indicated for the relief of acute bronchospasm
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicated disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arnuity Ellipta

Products Affected

- arnuity ellipta inhalation aerosol powder
breath activated 100 mcg/act, 200 mcg/act

QL Criteria	1 blister Per 1 Day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arnuity Ellipta

Products Affected

- arnuity ellipta inhalation aerosol powder
breath activated 50 mcg/act

QL Criteria	1 blister Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arymo ER

Products Affected

- arymo er oral tablet extended release
abuse-deterrent 15 mg, 30 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arymo ER

Products Affected

- arymo er oral tablet extended release abuse-deterrent 60 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Arzerra

Products Affected

- arzerra

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Arzerra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Asacol HD

Products Affected

- asacol hd

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ascomp-Codeine

Products Affected

- *ascomp-codeine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 capsules Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Asmanex 120 Metered Doses

Products Affected

- asmanex 120 metered doses

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Asmanex 14 Metered Doses

Products Affected

- asmanex 14 metered doses

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Asmanex 30 Metered Doses

Products Affected

- asmanex 30 metered doses

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Asmanex 60 Metered Doses

Products Affected

- asmanex 60 metered doses

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Asmanex 7 Metered Doses

Products Affected

- asmanex 7 metered doses

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Asmanex HFA

Products Affected

- asmanex hfa

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Assure 3 Test

Products Affected

- assure 3 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Assure 4 Test

Products Affected

- assure 4 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Assure II

Products Affected

- assure ii

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Assure II Check

Products Affected

- assure ii check

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Assure Platinum

Products Affected

- assure platinum

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Assure Prism multi Test

Products Affected

- assure prism multi test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Assure Pro Test

Products Affected

- assure pro test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Astagraf XL

Products Affected

- astagraf xl oral capsule extended release 24 hour 0.5 mg

QL Criteria	1 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Astagraf XL

Products Affected

- astagraf xl oral capsule extended release 24 hour 1 mg

QL Criteria	4 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atacand

Products Affected

- atacand oral tablet 16 mg, 4 mg, 8 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Atacand

Products Affected

- atacand oral tablet 32 mg

QL Criteria	1 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Atazanavir Sulfate

Products Affected

- *atazanavir sulfate oral capsule 150 mg, 300 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Atazanavir Sulfate

Products Affected

- *atazanavir sulfate oral capsule 200 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Atelvia

Products Affected

- atelvia

QL Criteria	4 tablets Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Atomoxetine HCl

Products Affected

- *atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atomoxetine HCl

Products Affected

- *atomoxetine hcl oral capsule 100 mg, 80 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atralin

Products Affected

- atralin

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Atripla

Products Affected

- atripla

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Atrovent HFA

Products Affected

- atrovent hfa

QL Criteria	2 inhalers Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Aubagio

Products Affected

- aubagio

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Aubagio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Austedo

Products Affected

- austedo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Austedo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Auvi-Q

Products Affected

- auvi-q injection solution auto-injector 0.1 mg/0.1ml

PA Criteria	Criteria Details
Covered Uses	Emergency treatment of allergic reactions
Exclusion Criteria	Coverage is not provided for patients weighing less than 7.5kg (16.5 pounds)
Required Medical Information	For patients weighing greater than 15 kg (33 pounds) - A documented diagnosis of an allergic reaction in patients who are at risk for or have a history of anaphylactic reaction and the individual or their caregiver requires an auto injector with audio or visual cues for administration For patients weighing 7.5 to 15kg (16.5 to 33 pounds) - Emergency treatment of allergic reactions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Auvi-Q

Products Affected

- auvi-q injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml

PA Criteria	Criteria Details
Covered Uses	Emergency treatment of allergic reactions
Exclusion Criteria	Coverage is not provided for patients weighing less than 7.5kg (16.5 pounds)
Required Medical Information	For patients weighing greater than 15 kg (33 pounds) - A documented diagnosis of an allergic reaction in patients who are at risk for or have a history of anaphylactic reaction and the individual or their caregiver requires an auto injector with audio or visual cues for administration For patients weighing 7.5 to 15kg (16.5 to 33 pounds) - Emergency treatment of allergic reactions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 injections Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Avalide

Products Affected

- avalide oral tablet 150-12.5 mg, 300-12.5 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avandia

Products Affected

- avandia oral tablet 2 mg, 4 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Avapro

Products Affected

- avapro

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Avita

Products Affected

- *avita*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Avodart

Products Affected

- avodart

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Avonex

Products Affected

- avonex

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Avonex Pen

Products Affected

- avonex pen intramuscular auto-injector kit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Avonex Prefilled

Products Affected

- avonex prefilled intramuscular prefilled syringe kit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Azilect

Products Affected

- azilect

QL Criteria	1 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Azor

Products Affected

- azor

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Azulfidine

Products Affected

- azulfidine

QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Azulfidine EN-tabs

Products Affected

- azulfidine en-tabs

QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bactroban

Products Affected

- bactroban external cream

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Balsalazide Disodium

Products Affected

- *balsalazide disodium*

QL Criteria	9 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Banzel

Products Affected

- banzel oral tablet

QL Criteria	8 tablets Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Baraclude

Products Affected

- baraclude oral tablet

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Baxdela

Products Affected

- baxdela oral

PA Criteria	Criteria Details
Covered Uses	Treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by designated susceptible bacteria
Exclusion Criteria	Known hypersensitivity to Baxdela or other fluoroquinolones
Required Medical Information	A documented diagnosis of acute bacterial skin and skin structure infections (ABSSSI) caused by one the following susceptible pathogens: Gram-positive organisms include Staphylococcus aureus (including methicillin-resistant [MRSA] and methicillinsusceptible [MSSA] isolates), Staphylococcus haemolyticus, Staphylococcus lugdunensis, Streptococcus agalactiae, Streptococcus anginosus Group (including Streptococcus anginosus, Streptococcus intermedius, and Streptococcus constellatus), Streptococcus pyogenes, or Enterococcus faecalis. Gram-negative organisms include: Escherichia coli, Enterobacter cloacae, Klebsiella pneumoniae, and Pseudomonas aeruginosa.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	28 tablets Per 1 fill
Notes/References	
Revision Date	Prior Authorization: November 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Bayer Breeze 2 Test

Products Affected

- bayer breeze 2 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bayer Contour Test

Products Affected

- bayer contour test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bebulin

Products Affected

- bebulin

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Belbuca

Products Affected

- belbuca

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	1 film Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Belsomra

Products Affected

- belsomra

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

BeneFIX

Products Affected

- benefix intravenous kit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Benicar

Products Affected

- benicar

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Benicar HCT

Products Affected

- benicar hct

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Benlysta

Products Affected

- benlysta intravenous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/benlysta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Benlysta

Products Affected

- benlysta subcutaneous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/benlysta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Benznidazole

Products Affected

- *benznidazole oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	Treatment of Chagas disease (American trypanosomiasis), caused by <i>Trypanosoma cruzi</i> in pediatric patients 2 to 12 years of age.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chagas disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: January 11, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Benznidazole

Products Affected

- *benznidazole oral tablet 12.5 mg*

PA Criteria	Criteria Details
Covered Uses	Treatment of Chagas disease (American trypanosomiasis), caused by <i>Trypanosoma cruzi</i> in pediatric patients 2 to 12 years of age.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chagas disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: January 11, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Berinert

Products Affected

- berinert

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Betamethasone Dipropionate Aug

Products Affected

- *betamethasone dipropionate aug external gel*
- *betamethasone dipropionate aug external ointment*

QL Criteria	100 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Betamethasone Dipropionate Aug

Products Affected

- *betamethasone dipropionate aug external lotion*

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Betaseron

Products Affected

- betaseron subcutaneous kit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bethkis

Products Affected

- bethkis

QL Criteria	56 ampules Per 30 DAYSS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bevespi Aerosphere

Products Affected

- bevespi aerosphere

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bevyxxa

Products Affected

- bevyxxa

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE.
Exclusion Criteria	Active pathological bleeding, severe hypersensitivity reaction to Bevyxxa, or for anyone with prosthetic heart valves.
Required Medical Information	Member is requesting product for use of prophylaxis of VTE and is currently taking Bevyxxa during hospitalization and will be continuing therapy following discharge from the hospital.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 capsule Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bexarotene

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Targretin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bicalutamide

Products Affected

- *bicalutamide*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Biktarvy

Products Affected

- biktarvy

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bimatoprost

Products Affected

- *bimatoprost ophthalmic*

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Binosto

Products Affected

- binosto

QL Criteria	4 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bioscanner Glucose Test

Products Affected

- bioscanner glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bivigam

Products Affected

- bivigam

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Blood Glucose Test

Products Affected

- *blood glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Boniva

Products Affected

- boniva oral tablet 150 mg

QL Criteria	1 tablet Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bonjesta

Products Affected

- bonjesta

PA Criteria	Criteria Details
Covered Uses	Nausea and vomiting in pregnant women
Exclusion Criteria	
Required Medical Information	A documented diagnosis of nausea and vomiting in a pregnant woman who does not respond to conservative management (i.e. trigger avoidance, small frequent meals, etc) and a documented contraindication, intolerance, allergy, or failure of an adequate trial of one week of any of the following: otc doxylamine, or otc pyridoxine (vit B6), or metoclopramide, or promethazine, or ondansetron
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 01, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bosulif

Products Affected

- bosulif oral tablet 100 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bosulif

Products Affected

- bosulif oral tablet 400 mg, 500 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Botox

Products Affected

- botox

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Braftovi

Products Affected

- braftovi oral capsule 50 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Braftovi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Braftovi

Products Affected

- braftovi oral capsule 75 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Braftovi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bravelle

Products Affected

- bravelle

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Breo Ellipta

Products Affected

- breo ellipta inhalation aerosol powder
breath activated 100-25 mcg/inh

QL Criteria	2 blister Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Breo Ellipta

Products Affected

- breo ellipta inhalation aerosol powder
breath activated 200-25 mcg/inh

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Brilinta

Products Affected

- brilinta oral tablet 60 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Brilinta

Products Affected

- brilinta oral tablet 90 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Brisdelle

Products Affected

- brisdelle

PA Criteria	Criteria Details
Covered Uses	Moderate to severe vasomotor symptoms associated with menopause
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Briviact

Products Affected

- briviact oral solution

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 ML Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: May 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Briviact

Products Affected

- briviact oral tablet

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: May 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Brovana

Products Affected

- brovana

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 milliliters Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Budesonide

Products Affected

- budesonide inhalation*

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	For ages 5-8 documented inability to use metered dose inhalers, No prior authorization required for children 1-4 years of age. Medical Exception allowed for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory and for Nasal Polyps when all criteria met: A diagnosis of chronic sinusitis with nasal polyposis, endoscopic sinus surgery has been performed, and standard nasal steroid sprays have been used as part of post-operative management and have failed.
Age Restrictions	Less than 8 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	4 ML Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Budesonide ER

Products Affected

- *budesonide er oral tablet extended release*
24 hour

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bunavail

Products Affected

- bunavail buccal film 2.1-0.3 mg

QL Criteria	6 films Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bunavail

Products Affected

- bunavail buccal film 4.2-0.7 mg, 6.3-1 mg

QL Criteria	3 films Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buphenyl

Products Affected

- buphenyl oral powder 3 gm/tsp
- buphenyl oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Buprenorphine

Products Affected

- *buprenorphine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 patches Per 28 Days
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual*

QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl sublingual tablet sublingual*

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

BuPROPion HCl ER (XL)

Products Affected

- *bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

BuPROPion HCl ER (XL)

Products Affected

- *bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Butalbital-APAP-Caff-Cod

Products Affected

- *butalbital-apap-caff-cod*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Butalbital-ASA-Caff-Codeine

Products Affected

- *butalbital-asa-caff-codeine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Butorphanol Tartrate

Products Affected

- *butorphanol tartrate nasal*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 bottles Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Butrans

Products Affected

- butrans

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 patches Per 28 Days
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bydureon

Products Affected

- bydureon subcutaneous pen-injector

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 pens Per 1 month
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bydureon

Products Affected

- bydureon subcutaneous suspension reconstituted er

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 vials Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bydureon BCise

Products Affected

- bydureon bcise

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 pens Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: December 13, 2017

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Byetta 10 MCG Pen

Products Affected

- byetta 10 mcg pen subcutaneous solution pen-injector

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 pen Per 30 Days
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Byetta 5 MCG Pen

Products Affected

- byetta 5 mcg pen subcutaneous solution pen-injector

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 pen Per 30 Days
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bystolic

Products Affected

- bystolic oral tablet 10 mg, 2.5 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	Treatment of hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Bystolic

Products Affected

- bystolic oral tablet 20 mg

PA Criteria	Criteria Details
Covered Uses	Treatment of hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Byvalson

Products Affected

- byvalson

PA Criteria	Criteria Details
Covered Uses	Treatment of hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cabometyx

Products Affected

- cabometyx

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Caduet

Products Affected

- caduet oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Calcipotriene-Betameth Diprop

Products Affected

- *calcipotriene-betameth diprop*

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

QL Criteria	1 bottle Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Calquence

Products Affected

- calquence

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Calquence.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: January 11, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cambia

Products Affected

- cambia

PA Criteria	Criteria Details
Covered Uses	Acute treatment of migraine attacks with or without aura in adults 18 years of age or older
Exclusion Criteria	Not indicated for the prophylactic therapy of migraine
Required Medical Information	A documented diagnosis of a migraine attack
Age Restrictions	18 and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement.
QL Criteria	9 pack Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Canasa

Products Affected

- canasa

QL Criteria	1 suppository Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Candesartan Cilexetil

Products Affected

- *candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Capecitabine

Products Affected

- *capecitabine*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Capex

Products Affected

- capex

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Caprelsa

Products Affected

- caprelsa oral tablet 100 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Caprelsa

Products Affected

- caprelsa oral tablet 300 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Carbaglu

Products Affected

- carbaglu

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Carbinoxamine Maleate

Products Affected

- *carbinoxamine maleate oral tablet 6 mg*

PA Criteria	Criteria Details
Covered Uses	Seasonal and perennial allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods, mild uncomplicated allergic skin manifestations of urticaria and angioedema, dermatographism, as therapy for anaphylactic reactions adjunctive to epinephrine, amelioration of the severity of allergic reactions to blood or plasma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seasonal and perennial allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods, mild uncomplicated allergic skin manifestations of urticaria and angioedema, dermatographism, as therapy for anaphylactic reactions adjunctive to epinephrine, or amelioration of the severity of allergic reactions to blood or plasma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating stability or improvement in symptoms from baseline.
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: January 09, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cardizem CD

Products Affected

- cardizem cd oral capsule extended release
24 hour 120 mg, 180 mg, 360 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cardizem CD

Products Affected

- cardizem cd oral capsule extended release
24 hour 240 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cardizem LA

Products Affected

- cardizem la oral tablet extended release 24 hour 120 mg

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cardizem LA

Products Affected

- cardizem la oral tablet extended release 24 hour 180 mg, 300 mg, 360 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cardizem LA

Products Affected

- cardizem la oral tablet extended release 24 hour 240 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cardura XL

Products Affected

- cardura xl

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CareSens N Glucose Test

Products Affected

- caresens n glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Carimune NF

Products Affected

- carimune nf intravenous solution reconstituted 12 gm, 6 gm

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CaroSpir

Products Affected

- carospir

PA Criteria	Criteria Details
Covered Uses	Treatment of NYHA Class III and Class IV heart failure and reduced ejection fraction, use as an add-on therapy for the treatment of hypertension, and for the management of edema in adult cirrhotic patients when edema is not responsive to fluid and sodium restrictions
Exclusion Criteria	Hyperkalemia, Addisons disease, concomitant use of eplerenone
Required Medical Information	A documented diagnosis of severe heart failure (NYHA class III-IV) and has a left ventricular ejection fraction less than or equal to 35%, a documented diagnosis of hypertension and requested drug is being used as add on therapy, or a documented diagnosis of Edema associated with Cirrhosis, and there is documentation of an inability to swallow tablets/capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	80 MLS Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cartia XT

Products Affected

- *cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cartia XT

Products Affected

- *cartia xt oral capsule extended release 24 hour 240 mg*

QL Criteria	2 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Carvedilol Phosphate ER

Products Affected

- *carvedilol phosphate er*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Casodex

Products Affected

- casodex

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cayston

Products Affected

- cayston

QL Criteria	3 vials Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CeleBREX

Products Affected

- celebrex

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Celecoxib

Products Affected

- *celecoxib oral*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CeleXA

Products Affected

- celexa oral tablet 10 mg, 20 mg

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CeleXA

Products Affected

- celexa oral tablet 40 mg

QL Criteria	1 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Centany

Products Affected

- centany

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cerdelga

Products Affected

- cerdelga

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cerezyme

Products Affected

- cerezyme intravenous solution reconstituted 400 unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cesamet

Products Affected

- cesamet

QL Criteria	2 capsules Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cetrotide

Products Affected

- cetrotide subcutaneous kit 0.25 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cevimeline HCl

Products Affected

- *cevimeline hcl*

QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Chantix

Products Affected

- chantix

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Chantix Continuing Month Pak

Products Affected

- chantix continuing month pak

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Chenodal

Products Affected

- chenodal

PA Criteria	Criteria Details
Covered Uses	For treatment of cholesterol-type gallstones in patients over 18 years of age and have tried and failed 2 years of generic Actigall (ursodiol) therapy and are not able to undergo surgery due to systemic disease or age, and for treatment of diagnosed Cerebrotendinous Xanthomatosis (CTX) in patients over 18 years of age
Exclusion Criteria	Intrahepatic duct calculus, chronic constipation in patients with cholesterol gallstones, Prophylaxis of recurrent gallstones, Hyperlipidemia, Rheumatoid Arthritis
Required Medical Information	Prior to initial coverage for gallstone disease, a cholecystogram or other appropriate imaging studies is required to determine presence of radiolucent gallstones, stones that are transparent to x-rays. Due to high risk of hepatotoxicity and adverse effects, for the first 3 months, authorization is required each month pending hepatic function tests (for both gallstones and CTX). After initial 3 months, authorization required every 3 months for length of treatment, pending hepatic function tests. At 6 months prior to authorization, the following results are required, serum cholesterol levels, hepatic function test, and cholecystogram (monitor dissolution of stones). Safety of use beyond a total of 24 months has not been established
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month (initial authorization), 3 month (reauthorization)
Other Criteria	Max authorization up to 2 years
Notes/References	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cholbam

Products Affected

- cholbam

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Cholbam.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Chorionic Gonadotropin

Products Affected

- *chorionic gonadotropin intramuscular*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ciclodan

Products Affected

- ciclodan external solution

PA Criteria	Criteria Details
Covered Uses	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Failure of an adequate trial of one systemic oral alternative is terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail), OR If member has hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or is female and is pregnant and/or breastfeeding. (No trial needed)
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ciclopirox

Products Affected

- *ciclopirox external solution*

PA Criteria	Criteria Details
Covered Uses	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Failure of an adequate trial of one systemic oral alternative is terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail), OR If member has hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or is female and is pregnant and/or breastfeeding. (No trial needed)
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cimduo

Products Affected

- cimduo

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cimzia

Products Affected

- cimzia subcutaneous kit 2 x 200 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cimzia Prefilled

Products Affected

- cimzia prefilled

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cimzia Starter Kit

Products Affected

- cimzia starter kit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cinqair

Products Affected

- cinqair

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/RESP/Cinqair.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cinryze

Products Affected

- cinryze

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	17 vials Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 10 mg, 20 mg*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 40 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Claravis

Products Affected

- *claravis*

PA Criteria	Criteria Details
Covered Uses	Severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member is enrolled in the FDA iPLEDGE program and, because of significant adverse reactions associated with its use, should be reserved for patients with multiple severe nodular acne who are unresponsive to conventional therapy, including topical acne products and systemic antibiotics. Treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	
QL Criteria	2 Capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clarinet

Products Affected

- clarinet oral tablet

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clarinet-D 12 Hour

Products Affected

- clarinet-d 12 hour

QL Criteria	2 TB12 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clever Chek Auto-Code

Products Affected

- clever chek auto-code

QL Criteria	1 meter Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clever Chek Auto-Code Test

Products Affected

- clever chek auto-code test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clever Chek Auto-Code Voice

Products Affected

- clever chek auto-code voice in vitro

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clever Chek Test

Products Affected

- clever chek test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clever Choice Auto-Code Test

Products Affected

- clever choice auto-code test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clever Choice Micro Test

Products Affected

- clever choice micro test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Climara

Products Affected

- climara

QL Criteria	4 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Climara Pro

Products Affected

- climara pro

QL Criteria	1 box (4 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobetasol Propionate

Products Affected

- *clobetasol propionate external cream*
- *clobetasol propionate external ointment*
- *clobetasol propionate external gel*

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobetasol Propionate

Products Affected

- *clobetasol propionate external foam*
- *clobetasol propionate external solution*

QL Criteria	100 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobetasol Propionate

Products Affected

- *clobetasol propionate external liquid*

QL Criteria	125 ML Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobetasol Propionate

Products Affected

- *clobetasol propionate external lotion*
- *clobetasol propionate external shampoo*

QL Criteria	236 ML Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobetasol Propionate E

Products Affected

- *clobetasol propionate e*

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobetasol Propionate Emulsion

Products Affected

- *clobetasol propionate emulsion*

QL Criteria	100 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobex

Products Affected

- clobex

QL Criteria	236 MLS Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clobex Spray

Products Affected

- clobex spray

QL Criteria	125 MLS Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clodan

Products Affected

- *clodan external shampoo*

QL Criteria	236 ML Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CloNIDine HCl ER

Products Affected

- *clonidine hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CloZAPine

Products Affected

- *clozapine oral tablet 100 mg*
- *clozapine oral tablet dispersible 100 mg*

QL Criteria	9 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CloZAPine

Products Affected

- *clozapine oral tablet 25 mg, 50 mg*
- *clozapine oral tablet dispersible 25 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg*

QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 200 mg*

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clozaril

Products Affected

- clozaril oral tablet 100 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Schizoaffective disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia or Schizoaffective disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Schizophrenia or Schizoaffective disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	9 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Clozaril

Products Affected

- clozaril oral tablet 25 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Schizoaffective disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia or Schizoaffective disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Schizophrenia or Schizoaffective disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Coagadex

Products Affected

- coagadex

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Codeine Sulfate

Products Affected

- *codeine sulfate oral tablet 15 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	24 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Codeine Sulfate

Products Affected

- *codeine sulfate oral tablet 30 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Codeine Sulfate

Products Affected

- *codeine sulfate oral tablet 60 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Colazal

Products Affected

- colazal

QL Criteria	9 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Colchicine

Products Affected

- *colchicine oral*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Colcrys

Products Affected

- colcrys

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CombiPatch

Products Affected

- combipatch

QL Criteria	8 patches Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Combivent Respimat

Products Affected

- combivent respimat

QL Criteria	2 inhalers Per 1 month
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cometriq (100 mg Daily Dose)

Products Affected

- cometriq (100 mg daily dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 kits Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cometriq (140 mg Daily Dose)

Products Affected

- cometriq (140 mg daily dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 caupsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cometriq (60 mg Daily Dose)

Products Affected

- cometriq (60 mg daily dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 kits Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Complera

Products Affected

- complera

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Concerta

Products Affected

- concerta oral tablet extended release 18 mg, 27 mg, 54 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Concerta

Products Affected

- concerta oral tablet extended release 36 mg

QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ConZip

Products Affected

- conzip

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Cool Blood Glucose Test Strips

Products Affected

- cool blood glucose test strips

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Copaxone

Products Affected

- copaxone subcutaneous solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/glatiramer.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Copiktra

Products Affected

- copiktra

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/copiktra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cordran

Products Affected

- cordran external cream 0.05 %
- cordran external lotion

QL Criteria	4 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cordran

Products Affected

- cordran external ointment

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cordran

Products Affected

- cordran external tape

QL Criteria	1 roll Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Coreg CR

Products Affected

- coreg cr

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CoreMino

Products Affected

- coremino

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 13, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Corifact

Products Affected

- corifact

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Corlanor

Products Affected

- corlanor

PA Criteria	Criteria Details
Covered Uses	FDA labeled use for heart failure
Exclusion Criteria	
Required Medical Information	Documentation of stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater or equal to 70 beats per minute and who are on maximally tolerated doses of beta-blockers (such as bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate, metoprolol succinate-HCTZ, or nevigolol) or have a documented contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cortifoam

Products Affected

- cortifoam

QL Criteria	30 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cosentyx

Products Affected

- cosentyx

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cosentyx.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cosentyx Sensoready Pen

Products Affected

- cosentyx sensoready pen subcutaneous solution auto-injector 150 mg/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cosentyx.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cotellic

Products Affected

- cotellic

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	63 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cotempla XR-ODT

Products Affected

- cotempla xr-odt

PA Criteria	Criteria Details
Covered Uses	Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in pediatric patients 6 to 17 years of age.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
Age Restrictions	Approved for patients 6 to 17 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD in pediatric patients 6 to 17 years of age AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cozaar

Products Affected

- cozaar oral tablet 25 mg, 50 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Crestor

Products Affected

- crestor

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cuprimine

Products Affected

- cuprimine oral capsule 250 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cuvitru

Products Affected

- cuvitru

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CVS Advanced Glucose Test

Products Affected

- cvs advanced glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

CVS Nicotine

Products Affected

- cvs nicotine transdermal patch 24 hour 14 mg/24hr, 7 mg/24hr*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CVS Nicotine Polacrilex

Products Affected

- *cvs nicotine polacrilex mouth/throat lozenge*
4 mg

QL Criteria	20 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cycloset

Products Affected

- cycloset

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cymbalta

Products Affected

- cymbalta oral capsule delayed release
particles 20 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cymbalta

Products Affected

- cymbalta oral capsule delayed release particles 30 mg, 60 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cystagon

Products Affected

- cystagon

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Cystaran

Products Affected

- cystaran

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ML Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Daklinza

Products Affected

- daklinza oral tablet 30 mg, 60 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Daklinza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Daklinza

Products Affected

- daklinza oral tablet 90 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Daklinza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dalfampridine ER

Products Affected

- *dalfampridine er*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Daliresp

Products Affected

- daliresp oral tablet 250 mcg

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Daliresp

Products Affected

- daliresp oral tablet 500 mcg

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dapsone

Products Affected

- *dapsone external*

QL Criteria	60 grams Per 30 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Darifenacin Hydrobromide ER

Products Affected

- *darifenacin hydrobromide er*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Daytrana

Products Affected

- daytrana

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 patch Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Delstrigo

Products Affected

- delstrigo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Delzicol

Products Affected

- delzicol

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Depen Titratabs

Products Affected

- depen titratabs

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Descovy

Products Affected

- descovy

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Desloratadine

Products Affected

- *desloratadine oral tablet*
- *desloratadine oral tablet dispersible 2.5 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Desoxyn

Products Affected

- desoxyn

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Desvenlafaxine ER

Products Affected

- *desvenlafaxine er*

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Desvenlafaxine Succinate ER

Products Affected

- *desvenlafaxine succinate er*

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Detrol LA

Products Affected

- detrol la

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dexedrine

Products Affected

- dexedrine oral capsule extended release 24 hour 10 mg, 15 mg

QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexedrine

Products Affected

- dexedrine oral capsule extended release 24 hour 5 mg

QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dexilant

Products Affected

- dexilant

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er oral capsule*
extended release 24 hour 10 mg, 15 mg, 30
mg, 40 mg, 5 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er oral capsule
extended release 24 hour 20 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er oral capsule*
extended release 24 hour 25 mg, 35 mg

QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dextroamphetamine Sulfate

Products Affected

- dextroamphetamine sulfate oral solution*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) OR Narcolepsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD OR Narcolepsy AND there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	40 milliliters Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diastat AcuDial

Products Affected

- diastat acudial

QL Criteria	1 pack Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diastat Pediatric

Products Affected

- diastat pediatric

QL Criteria	1 pack Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

DiaTrue Plus Test

Products Affected

- *diatruue plus test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

DiazePAM

Products Affected

- *diazepam rectal*

QL Criteria	1 box Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dibenzylidene

Products Affected

- dibenzylidene

QL Criteria	12 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diclegis

Products Affected

- diclegis

PA Criteria	Criteria Details
Covered Uses	Nausea and vomiting in pregnant women
Exclusion Criteria	
Required Medical Information	A documented diagnosis of nausea and vomiting in a pregnant woman who does not respond to conservative management (i.e. trigger avoidance, small frequent meals, etc) and a documented contraindication, intolerance, allergy, or failure of an adequate trial of one week of any of the following: otc doxylamine, or otc pyridoxine (vit B6), or metoclopramide, or promethazine, or ondansetron
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 01, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 1%*

QL Criteria	200 GM Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 3 %*

PA Criteria	Criteria Details
Covered Uses	Actinic keratoses (AK)
Exclusion Criteria	Documentation of any of the following patients/situations: use in treatment of postoperative pain after coronary artery bypass graft (CABG) surgery, any known hypersensitivity to diclofenac or any component of the formulation, any history of Asthma and aspirin triad, the planned area of application includes non-intact skin, or if the medication will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	Documentation that sun avoidance is indicated during therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	100 grams Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 29, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal solution*

QL Criteria	10 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dificid

Products Affected

- difucid

QL Criteria	20 tablets Per 1 fill
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dihydroergotamine Mesylate

Products Affected

- *dihydroergotamine mesylate nasal*

QL Criteria	9 ML Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dilaudid

Products Affected

- dilaudid oral liquid

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	22 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dilaudid

Products Affected

- dilaudid oral tablet 2 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	11 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Dilaudid

Products Affected

- dilaudid oral tablet 4 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	5 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Dilaudid

Products Affected

- dilaudid oral tablet 8 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diltiazem HCl ER

Products Affected

- *diltiazem hcl er oral capsule extended release 24 hour 240 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diltiazem HCl ER Beads

Products Affected

- *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg, 420 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diltiazem HCl ER Beads

Products Affected

- *diltiazem hcl er beads oral capsule extended release 24 hour 240 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diltiazem HCl ER Coated Beads

Products Affected

- *diltiazem hcl er coated beads oral capsule*
extended release 24 hour 120 mg, 360 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diltiazem HCl ER Coated Beads

Products Affected

- diltiazem hcl er coated beads oral capsule
extended release 24 hour 180 mg, 300 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

DilTIAZem HCl ER Coated Beads

Products Affected

- *diltiazem hcl er coated beads oral capsule*
extended release 24 hour 240 mg

QL Criteria	2 Capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dilt-XR

Products Affected

- *dilt-xr oral capsule extended release 24 hour 240 mg*

QL Criteria	2 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diovan

Products Affected

- diovan

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diovan HCT

Products Affected

- diovan hct

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dipentum

Products Affected

- dipentum

QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diprolene

Products Affected

- diprolene external lotion

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Diprolene

Products Affected

- diprolene external ointment

QL Criteria	100 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ditropan XL

Products Affected

- ditropan xl oral tablet extended release 24 hour 10 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ditropan XL

Products Affected

- ditropan xl oral tablet extended release 24 hour 5 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dolophine

Products Affected

- dolophine oral tablet 10 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dolophine

Products Affected

- dolophine oral tablet 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Donepezil HCl

Products Affected

- *donepezil hcl*

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Doptelet

Products Affected

- doptelet oral tablet 20 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Doptelet.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 /day for 5 days Per 30 Days
Notes/References	
Revision Date	Prior Authorization: June 27, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Doxepin HCl

Products Affected

- *doxepin hcl external*

QL Criteria	45 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Doxercalciferol

Products Affected

- *doxercalciferol oral*

QL Criteria	1 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Doxycycline

Products Affected

- *doxycycline*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Doxycycline Monohydrate

Products Affected

- *doxycycline monohydrate oral capsule 150 mg*

QL Criteria	1 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Doxycycline Monohydrate

Products Affected

- *doxycycline monohydrate oral capsule 75 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dronabinol

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Duavee

Products Affected

- duavee

QL Criteria	1 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Duetact

Products Affected

- duetact

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Duexis

Products Affected

- duexis

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dulera

Products Affected

- dulera

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 20 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 30 mg, 40 mg, 60 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Duo-Care Test

Products Affected

- duo-care test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Duopa

Products Affected

- duopa enteral

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/antiparkinsons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	100 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: July 31, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dupixent

Products Affected

- dupixent subcutaneous solution prefilled syringe 300 mg/2ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Dupixent.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Duragesic-100

Products Affected

- duragesic-100

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 patches Per 30 Days
Notes/References	Annual Review: 09/2016
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Duragesic-12

Products Affected

- duragesic-12

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 patches Per 30 Days
Notes/References	Annual Review: 09/2016
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Duragesic-25

Products Affected

- duragesic-25

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 patches Per 30 Days
Notes/References	Annual Review: 09/2016
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Duragesic-50

Products Affected

- duragesic-50

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 patches Per 30 Days
Notes/References	Annual Review: 09/2016
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Duragesic-75

Products Affected

- duragesic-75

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 patches Per 30 Days
Notes/References	Annual Review: 09/2016
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Durolane

Products Affected

- durolane intra-articular

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dutasteride

Products Affected

- *dutasteride oral*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dutoprol

Products Affected

- dutoprol oral tablet extended release 24 hour 100-12.5 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dutoprol

Products Affected

- dutoprol oral tablet extended release 24 hour 25-12.5 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dutoprol

Products Affected

- dutoprol oral tablet extended release 24 hour 50-12.5 mg

QL Criteria	1 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Duzallo

Products Affected

- duzallo

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperuricemia associated with gout in patients who have not achieved target serum uric acid levels with a medically appropriate daily dose of allopurinol alone.
Exclusion Criteria	For the treatment of asymptomatic hyperuricemia, severe renal impairment, end stage renal disease, kidney transplant recipients, or patients on dialysis, tumor lysis syndrome or Lesch-Nyhan syndrome, or for anyone with a known hypersensitivity to allopurinol, including previous occurrence of skin rash.
Required Medical Information	A documented diagnosis of hyperuricemia associated with gout and the member has a documented trial of allopurinol and has not achieved target serum uric acid levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: October 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dyanavel XR

Products Affected

- dyanavel xr

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	240 ML Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Dysport

Products Affected

- dysport

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Easy Plus II Glucose Test

Products Affected

- *easy plus ii glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Step Test

Products Affected

- easy step test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Easy Talk Blood Glucose Test

Products Affected

- *easy talk blood glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Touch HealthPro Test

Products Affected

- easy touch healthpro test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Easy Touch Test

Products Affected

- easy touch test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Trak Blood Glucose Test

Products Affected

- *easy trak blood glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EasyGluco

Products Affected

- easygluco in vitro

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EasyGluco Plus

Products Affected

- easygluco plus in vitro

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EasyMax 15 Test

Products Affected

- easymax 15 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EASYMax Test

Products Affected

- easymax test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EasyPlus Blood Glucose Test

Products Affected

- *easyplus blood glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EasyPRO Blood Glucose Test

Products Affected

- easypro blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EasyPRO Plus

Products Affected

- easypro plus in vitro

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Econazole Nitrate

Products Affected

- *econazole nitrate external*

QL Criteria	85 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Edarbi

Products Affected

- edarbi

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Edarbyclor

Products Affected

- edarbyclor

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Edurant

Products Affected

- edurant

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Effexor XR

Products Affected

- effexor xr oral capsule extended release 24 hour 150 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Effexor XR

Products Affected

- effexor xr oral capsule extended release 24 hour 37.5 mg, 75 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Effient

Products Affected

- effient

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS) managed with percutaneous coronary intervention which includes unstable angina or non-ST elevation myocardial infarction or ST elevation myocardial infarction (MI)
Exclusion Criteria	History of Stroke or transient ischemic attack (TIA)
Required Medical Information	Member has a documented diagnosis of acute coronary syndrome (ACS) and is managed by percutaneous coronary intervention (PCI), which includes unstable angina, non-ST-elevation myocardial infarction (NSTEMI), or ST -elevation myocardial infarction (STEMI) managed with primary or delayed PCI and member has no prior history of stroke or transient ischemic attack (TIA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: May 22, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Elaprase

Products Affected

- elaprase

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Elelyso

Products Affected

- elelyso

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Element Compact Test

Products Affected

- *element compact test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Element Test

Products Affected

- element test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Elestrin

Products Affected

- elestrin

QL Criteria	52 GM Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eletriptan Hydrobromide

Products Affected

- *eletriptan hydrobromide*

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Elidel

Products Affected

- elidel

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis
Exclusion Criteria	
Required Medical Information	FOR MEMBERS LESS THAN 2 YEARS OF AGE: Covered for the treatment of mild to moderate atopic dermatitis (eczema) for short-term use (up to 3 months). FOR MEMBERS OVER 2 YEARS OF AGE: A documented diagnosis of atopic dermatitis (eczema) and has a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for their condition, or they are being treated for atopic dermatitis (eczema) in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Children 2 years & younger - 3 months; Members greater than 2 years of age - 6 months
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eligard

Products Affected

- eligard

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eliquis

Products Affected

- eliquis oral tablet 2.5 mg

QL Criteria	60 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eliquis

Products Affected

- eliquis oral tablet 5 mg

QL Criteria	75 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eliquis Starter Pack

Products Affected

- eliquis starter pack

QL Criteria	1 pack Per 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elmiron

Products Affected

- elmiron

QL Criteria	90 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eloctate

Products Affected

- eloctate

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Embeda

Products Affected

- embeda oral capsule extended release 100-4 mg, 50-2 mg, 60-2.4 mg, 80-3.2 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Embeda

Products Affected

- embeda oral capsule extended release 20-0.8 mg, 30-1.2 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Embrace Blood Glucose Test

Products Affected

- embrace blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Embrace Evo Blood Glucose Test

Products Affected

- embrace evo blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Embrace Pro Glucose Test

Products Affected

- embrace pro glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Emend

Products Affected

- emend oral capsule 125 mg, 40 mg, 80 mg

QL Criteria	5 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emflaza

Products Affected

- emflaza oral suspension

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Emflaza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Emflaza

Products Affected

- emflaza oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Emflaza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Emgality

Products Affected

- emgality

PA Criteria	Criteria Details
Covered Uses	Episodic or chronic migraines
Exclusion Criteria	
Required Medical Information	INITIAL CRITERIA: A documented diagnosis of episodic or chronic migraines characterized by four or more headaches per month and member is at least 18 years of age or older. REAUTHORIZATION CRITERIA: Additional coverage will be provided if the member has experienced 2 fewer headaches per month or there is documentation of clinical response or disease stability.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months initially, 1 year renewal if 2 fewer headaches per month
Other Criteria	
QL Criteria	1 injection Per 1 month
Notes/References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Emsam

Products Affected

- emsam

QL Criteria	1 patch Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Emtriva

Products Affected

- emtriva oral capsule

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Emverm

Products Affected

- emverm

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Enablex

Products Affected

- enablex oral tablet extended release 24 hour 15 mg

QL Criteria	1 tablet Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Enablex

Products Affected

- enablex oral tablet extended release 24 hour 7.5 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enbrel

Products Affected

- enbrel subcutaneous solution prefilled syringe 25 mg/0.5ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Enbrel

Products Affected

- enbrel subcutaneous solution prefilled syringe 50 mg/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Enbrel

Products Affected

- enbrel subcutaneous solution reconstituted

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Enbrel Mini

Products Affected

- enbrel mini

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Enbrel SureClick

Products Affected

- enbrel sureclick subcutaneous solution auto-injector

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Endari

Products Affected

- endari

PA Criteria	Criteria Details
Covered Uses	To reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of sickle cell disease and of 2 or more painful crises within past 12 months. Patients renal and hepatic function will be routinely monitored while on this medication.
Age Restrictions	5 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria - There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	6 packets Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Endocet

Products Affected

- *endocet oral tablet 10-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Endocet

Products Affected

- endocet oral tablet 2.5-325 mg
- *endocet oral tablet 5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Endocet

Products Affected

- *endocet oral tablet 7.5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium*

QL Criteria	2 syringes Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Enstilar

Products Affected

- enstilar

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Entecavir

Products Affected

- *entecavir*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Entresto

Products Affected

- entresto

PA Criteria	Criteria Details
Covered Uses	Chronic heart failure (NYHA Class II-IV) and reduced ejection fraction
Exclusion Criteria	
Required Medical Information	A documented diagnosis of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 08/2017
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Entyvio

Products Affected

- entyvio

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Entyvio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Epaned

Products Affected

- epaned oral solution

QL Criteria	1 bottle Per 30 Days
Notes/ References	Annual Review: 08/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Epclusa

Products Affected

- epclusa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Epclusa.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Epidiolex

Products Affected

- epidiolex

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/epidiolex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	20 ml Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EPINEPHrine

Products Affected

- *epinephrine injection solution auto-injector*

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EpiPen 2-Pak

Products Affected

- epiPen 2-pak injection solution auto-injector

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EpiPen Jr 2-Pak

Products Affected

- epipen jr 2-pak injection solution auto-injector

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EPIsnap

Products Affected

- episnap

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Epogen

Products Affected

- epogen injection solution 10000 unit/ml, 2000 unit/ml, 20000 unit/ml, 3000 unit/ml, 4000 unit/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Epoprostenol Sodium

Products Affected

- *epoprostenol sodium*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EQ Nicotine

Products Affected

- *eq nicotine transdermal*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Erivedge

Products Affected

- erivedge

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Erleada

Products Affected

- erleada

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Erleada.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 05, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ertaczo

Products Affected

- ertaczo

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Esbriet

Products Affected

- esbriet oral capsule

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	9 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Esbriet

Products Affected

- esbriet oral tablet 267 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	9 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Esbriet

Products Affected

- esbriet oral tablet 801 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 20 mg, 5 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium oral capsule*
delayed release 20 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium oral capsule*
delayed release 40 mg

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estradiol

Products Affected

- *estradiol transdermal patch twice weekly*

QL Criteria	8 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Estradiol

Products Affected

- *estradiol transdermal patch weekly*

QL Criteria	4 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Estrogel

Products Affected

- estrogel

QL Criteria	50 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eszopiclone

Products Affected

- *eszopiclone*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eucrisa

Products Affected

- eucrisa

PA Criteria	Criteria Details
Covered Uses	Mild to moderate atopic dermatitis
Exclusion Criteria	Not covered for members under 2 years old
Required Medical Information	A documented diagnosis of mild to moderate atopic dermatitis
Age Restrictions	Not covered for members under 2 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Euflexxa

Products Affected

- euflexxa intra-articular solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Evamist

Products Affected

- evamist

QL Criteria	2 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Evekeo

Products Affected

- evekeo

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) OR Narcolepsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD OR Narcolepsy AND there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	120 tablets Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EvenCare + Blood Glucose Test

Products Affected

- evencare + blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EvenCare Blood Glucose Test

Products Affected

- evencare blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EvenCare G2 Test

Products Affected

- evencare g2 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EvenCare G3 Test

Products Affected

- evencare g3 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

EvenCare Mini Glucose Test

Products Affected

- evencare mini glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Evolution Autocode

Products Affected

- evolution autocode in vitro

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Evoxac

Products Affected

- evoxac

QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Evzio

Products Affected

- evzio injection solution auto-injector 2 mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Emergency treatment of known or suspected opioid overdose
Exclusion Criteria	
Required Medical Information	Medication is being used for emergency treatment of opioid overdose
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	30 days maximum Per 1 fill
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Exalgo

Products Affected

- exalgo oral tablet er 24 hour abuse-deterrent

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Exelderm

Products Affected

- exelderm

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Exelon

Products Affected

- exelon transdermal

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Exforge

Products Affected

- exforge

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Exforge HCT

Products Affected

- exforge hct

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 27, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Exjade

Products Affected

- exjade

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Anitdotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Extavia

Products Affected

- extavia subcutaneous kit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Extina

Products Affected

- extina

QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Eylea

Products Affected

- eylea intravitreal

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/EYE/opthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ez Smart Blood Glucose Test

Products Affected

- ez smart blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Plus Glucose Test

Products Affected

- ez smart plus glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ezetimibe

Products Affected

- *ezetimibe*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ezetimibe-Simvastatin

Products Affected

- *ezetimibe-simvastatin*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fabrazyme

Products Affected

- fabrazyme

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Famciclovir

Products Affected

- *famciclovir oral tablet 125 mg, 250 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Famciclovir

Products Affected

- *famciclovir oral tablet 500 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fanapt

Products Affected

- fanapt

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Farxiga

Products Affected

- farxiga

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Farydak

Products Affected

- farydak

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 EA Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Faslodex

Products Affected

- faslodex intramuscular solution 250 mg/5ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FazaClo

Products Affected

- fazaclor oral tablet dispersible 100 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	9 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FazaClo

Products Affected

- fazaclor oral tablet dispersible 12.5 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FazaClo

Products Affected

- fazaClo oral tablet dispersible 150 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	6 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FazaClo

Products Affected

- fazaclor oral tablet dispersible 200 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FazaClo

Products Affected

- fazaclor oral tablet dispersible 25 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Feiba

Products Affected

- feiba

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Felodipine ER

Products Affected

- *felodipine er*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Femring

Products Affected

- femring

QL Criteria	1 ring Per 90 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fenofibrate

Products Affected

- *fenofibrate oral capsule 150 mg, 50 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fenofibrate

Products Affected

- *fenofibrate oral tablet 120 mg, 40 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fenofibrate

Products Affected

- *fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fenofibric Acid

Products Affected

- *fenofibric acid oral capsule delayed release*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: July 31, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fenofibric Acid

Products Affected

- *fenofibric acid oral tablet*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fenoglide

Products Affected

- fenoglide

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FentaNYL

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 patches Per 30 Days
Notes/References	Annual Review: 09/2016
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

FentaNYL Citrate

Products Affected

- *fentanyl citrate buccal*

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
QL Criteria	120 Lozenges Per 30 Days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Fentora

Products Affected

- fentora buccal tablet 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
QL Criteria	120 tablets Per 30 Days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Ferriprox

Products Affected

- ferriprox

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Anitdotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fetzima

Products Affected

- fetzima

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fetzima Titration

Products Affected

- fetzima titration

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 CP24 Per 1 DAYS
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fibricor

Products Affected

- fibricor

QL Criteria	1 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fibryga

Products Affected

- fibryga

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Rias tap.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fifty50 Glucose Test 2.0

Products Affected

- fifty50 glucose test 2.0

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Finasteride

Products Affected

- *finasteride oral tablet 5 mg*

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of BPH (Benign Prostatic Hyperplasia). For female members, must have a documented diagnosis of hirsutism secondary to ovarian or adrenal dysfunction (for example, polycystic ovary syndrome, adrenal or ovarian tumor)and must not be pregnant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fioricet/Codeine

Products Affected

- fioricet/codeine oral capsule 50-300-40-30 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Fiorinal/Codeine #3

Products Affected

- fiorinal/codeine #3

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Firazyr

Products Affected

- firazyr

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 syringes Per 1 fill
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Firmagon

Products Affected

- firmagon

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Flebogamma DIF

Products Affected

- flebogamma dif

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Flector

Products Affected

- flector

QL Criteria	2 patch Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Flolan

Products Affected

- flolan

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Flovent Diskus

Products Affected

- flovent diskus

QL Criteria	2 blisters Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Flovent HFA

Products Affected

- flovent hfa inhalation aerosol 110 mcg/act, 44 mcg/act

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Flovent HFA

Products Affected

- flovent hfa inhalation aerosol 220 mcg/act

QL Criteria	2 inhalers Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fluocinonide

Products Affected

- *fluocinonide external*

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 10 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 20 mg*

QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 40 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

QL Criteria	4 capsules Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 60 mg*

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flurandrenolide

Products Affected

- *flurandrenolide external cream*
- *flurandrenolide external ointment*

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Flurandrenolide

Products Affected

- *flurandrenolide external lotion*

QL Criteria	4 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fluticasone-Salmeterol

Products Affected

- *fluticasone-salmeterol*

QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fluvastatin Sodium ER

Products Affected

- *fluvastatin sodium er*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fluvoxamine Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fluvoxamine Maleate

Products Affected

- *fluvoxamine maleate oral tablet 25 mg, 50 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fluvoxamine Maleate ER

Products Affected

- *fluvoxamine maleate er*

QL Criteria	2 cap Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Focalin

Products Affected

- focalin

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Focalin XR

Products Affected

- focalin xr

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Follistim AQ

Products Affected

- follistim aq subcutaneous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium*

QL Criteria	2 syringes Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA D10 2-in-1 Monitor

Products Affected

- fora d10 2-in-1 monitor

QL Criteria	1 meter Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA D15g 2-in-1 Monitor

Products Affected

- fora d15g 2-in-1 monitor

QL Criteria	1 meter Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA D15g Blood Glucose Test

Products Affected

- fora d15g blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA D20 2-in-1 Monitor

Products Affected

- fora d20 2-in-1 monitor

QL Criteria	1 meter Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA D20 Blood Glucose Test

Products Affected

- fora d20 blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fora D40/G31 Blood Glucose

Products Affected

- fora d40/g31 blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G20 Blood Glucose Test

Products Affected

- fora g20 blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA G30/Prem V10 Glucose Test

Products Affected

- fora g30/prem v10 glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fora GD20 Test

Products Affected

- fora gd20 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA GD50 Blood Glucose Test

Products Affected

- fora gd50 blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fora TN'G/TN'G Voice

Products Affected

- fora tn'g/tn'g voice

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA V10 Blood Glucose Test

Products Affected

- fora v10 blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA V12 Blood Glucose Test

Products Affected

- fora v12 blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA V20 Blood Glucose Test

Products Affected

- fora v20 blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FORA V30a Blood Glucose Test

Products Affected

- fora v30a blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ForaCare GD40 Test

Products Affected

- foracare gd40 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ForaCare premium V10 Test

Products Affected

- foracare premium v10 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ForaCare Test N Go Test

Products Affected

- foracare test n go test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Forfivo XL

Products Affected

- forfivo xl

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fortamet

Products Affected

- fortamet oral tablet extended release 24 hour 1000 mg

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fortamet

Products Affected

- fortamet oral tablet extended release 24 hour 500 mg

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Forteo

Products Affected

- forteo subcutaneous solution 600 mcg/2.4ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fortesta

Products Affected

- fortesta

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	4 grams Per 1 Day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FortisCare Test

Products Affected

- fortiscare test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fosamax

Products Affected

- fosamax oral tablet 70 mg

QL Criteria	4 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fosamax Plus D

Products Affected

- fosamax plus d

QL Criteria	4 tablets Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fragmin

Products Affected

- fragmin subcutaneous solution 10000 unit/ml, 12500 unit/0.5ml, 15000 unit/0.6ml, 18000 unit/0.72ml, 2500 unit/0.2ml, 5000 unit/0.2ml, 7500 unit/0.3ml, 95000 unit/3.8ml

QL Criteria	2 syringes Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FreeStyle InsuLinx Test

Products Affected

- freestyle insulinx test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FreeStyle Lite Test

Products Affected

- freestyle lite test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FreeStyle Precision Neo Test

Products Affected

- freestyle precision neo test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

FreeStyle Test

Products Affected

- freestyle test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Frova

Products Affected

- frova

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Frovatriptan Succinate

Products Affected

- *frovatriptan succinate*

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fulphila

Products Affected

- fulphila

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Fycompa

Products Affected

- fycompa oral tablet

QL Criteria	1 TABS Per 1 DAYS
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gabapentin

Products Affected

- *gabapentin oral capsule*

QL Criteria	6 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gabapentin

Products Affected

- *gabapentin oral solution 250 mg/5ml*

QL Criteria	40 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: July 31, 2018

Gabapentin

Products Affected

- *gabapentin oral tablet*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gabril

Products Affected

- gabril oral tablet 12 mg

QL Criteria	4 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gabril

Products Affected

- gabril oral tablet 16 mg

QL Criteria	3 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gabril

Products Affected

- gabril oral tablet 2 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gabitril

Products Affected

- gabitril oral tablet 4 mg

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Galafold

Products Affected

- galafold

QL Criteria	14 capsules Per 28 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Galantamine Hydrobromide

Products Affected

- *galantamine hydrobromide*

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Galantamine Hydrobromide ER

Products Affected

- *galantamine hydrobromide er*

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gammagard

Products Affected

- gammagard

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gammagard S/D Less IgA

Products Affected

- gammagard s/d less iga

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gammaked

Products Affected

- gammaked

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gammaplex

Products Affected

- gammaplex intravenous solution 10 gm/200ml, 20 gm/400ml, 5 gm/100ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gamunex-C

Products Affected

- gamunex-c

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ganirelix Acetate

Products Affected

- *ganirelix acetate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/inferility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gattex

Products Affected

- gattex

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gattex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GE100 Blood Glucose Test

Products Affected

- *ge100 blood glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gel-One

Products Affected

- gel-one intra-articular prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gelsyn-3

Products Affected

- gelsyn-3

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GenStrip 50

Products Affected

- genstrip 50

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GenVisc 850

Products Affected

- genvisc 850

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Genvoya

Products Affected

- genvoya

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Geodon

Products Affected

- geodon oral

PA Criteria	Criteria Details
Covered Uses	Bipolar disorder, Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Bipolar Disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Bipolar Disorder or Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GHT Test

Products Affected

- *ght test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gilenya

Products Affected

- gilenya

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Gilenya.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gilotrif

Products Affected

- gilotrif

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glassia

Products Affected

- glassia

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2018/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glatiramer Acetate

Products Affected

- *glatiramer acetate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/glatiramer.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glatopa

Products Affected

- glatopa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/glatiramer.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gleevec

Products Affected

- gleevec oral tablet 100 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gleevec

Products Affected

- gleevec oral tablet 400 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gleostine

Products Affected

- gleostine oral capsule 10 mg, 100 mg, 40 mg

PA Criteria	Criteria Details
Covered Uses	Primary or metastatic brain tumors following surgical and/or radiation therapy, Low-grade infiltrative supratentorial Astrocytoma/Oligodendroglioma, Anaplastic Gliomas, Glioblastoma, Intracranial or spinal ependymoma, Medulloblastoma, Hodgkins lymphoma which has progressed following initial chemotherapy
Exclusion Criteria	
Required Medical Information	Gleostine is covered for the following indications when criteria are met: (1) For the treatment of primary or metastatic brain tumors following surgical and/or radiation therapy, (2) For the treatment of the following Central Nervous System Cancers: Low-grade infiltrative supratentorial Astrocytoma/Oligodendroglioma, Anaplastic Gliomas, Glioblastoma, Intracranial or spinal ependymoma, or Medulloblastoma, or (3) For the treatment of Hodgkins lymphoma which has progressed following initial chemotherapy. Reauthorization Criteria: Diagnosis above has been met and there is no evidence of unacceptable toxicity or disease progression.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Revision Date	Prior Authorization: April 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	--

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GlucaGen Diagnostic

Products Affected

- glucagen diagnostic

QL Criteria	1 vial Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GlucaGen HypoKit

Products Affected

- glucagen hypokit

QL Criteria	1 box Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glucagon Emergency

Products Affected

- glucagon emergency

QL Criteria	2 kits Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gluco Perfect 3 Test

Products Affected

- gluco perfect 3 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glucocard 01 Sensor Plus

Products Affected

- glucocard 01 sensor plus

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glucocard Expression Test

Products Affected

- glucocard expression test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glucocard Shine Test

Products Affected

- glucocard shine test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glucocard Vital Test

Products Affected

- glucocard vital test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glucocard X-Sensor

Products Affected

- glucocard x-sensor

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GlucoCom Test

Products Affected

- glucom test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GlucoNavii Blood Glucose Test

Products Affected

- gluconavii blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glumetza

Products Affected

- glumetza oral tablet extended release 24 hour 1000 mg

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glumetza

Products Affected

- glumetza oral tablet extended release 24 hour 500 mg

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Glyxambi

Products Affected

- glyxambi

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gocovri

Products Affected

- gocovri

PA Criteria	Criteria Details
Covered Uses	Treatment of dyskinesia in patients with Parkinsons disease receiving levodopa based therapy, with or without concomitant dopaminergic medications
Exclusion Criteria	Contraindicated in patients with end stage renal disease
Required Medical Information	A documented diagnosis of dyskinesia associated with Parkinsons disease and member is currently receiving levodopa based therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gonal-f

Products Affected

- gonal-f

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gonal-f RFF

Products Affected

- gonal-f rff

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/inferility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gonal-f RFF Rediject

Products Affected

- gonal-f rff rediject

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/inferility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gralise

Products Affected

- gralise oral tablet 300 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gralise

Products Affected

- gralise oral tablet 600 mg

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Gralise Starter

Products Affected

- gralise starter

QL Criteria	1 starter pack Per 1 month
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Granix

Products Affected

- granix

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

GuanFACINE HCl ER

Products Affected

- *guanfacine hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Haegarda

Products Affected

- haegarda

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	16 kits Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Halobetasol Propionate

Products Affected

- *halobetasol propionate*

QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Harvoni

Products Affected

- harvoni

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Harvoni.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Helixate FS

Products Affected

- helixate fs

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hemangeol

Products Affected

- hemangeol

PA Criteria	Criteria Details
Covered Uses	Proliferating infantile hemangioma
Exclusion Criteria	History of asthma or bronchospasms
Required Medical Information	A documented diagnosis of proliferating infantile hemangioma requiring systemic therapy and documented all of the following: (1) Member was not born prematurely with a corrected age of less than 5 weeks, (2) Member does not weigh less than 2kg, have sustained heart rate less than 80 beats per minute, have greater than first degree heart block, or have decompensated heart failure, and (3) Member does not have sustained blood pressure less than 50/ 30mmHg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hemlibra

Products Affected

- hemlibra

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hemofil M

Products Affected

- hemofil m intravenous solution
reconstituted 1000 unit, 1700 unit, 250
unit, 500 unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hepsera

Products Affected

- hepsera

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hetlioz

Products Affected

- hetlioz

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/sedative-hypnotics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hizentra

Products Affected

- hizentra subcutaneous solution 1 gm/5ml, 10 gm/50ml, 2 gm/10ml, 4 gm/20ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

HM Nicotine

Products Affected

- *hm nicotine*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

HM Nicotine Polacrilex

Products Affected

- *hm nicotine polacrilex mouth/throat lozenge*
2 mg

QL Criteria	20 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Horizant

Products Affected

- horizant oral tablet extended release 300 mg

PA Criteria	Criteria Details
Covered Uses	Post-herpetic neuralgia and Restless leg syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Restless Leg Syndrome (RLS) or Post Herpetic Neuralgia (shingles)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Horizant

Products Affected

- horizant oral tablet extended release 600 mg

PA Criteria	Criteria Details
Covered Uses	Post-herpetic neuralgia and Restless leg syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Restless Leg Syndrome (RLS) or Post Herpetic Neuralgia (shingles)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

HP Acthar

Products Affected

- hp acthar

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/acthar.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humate-P

Products Affected

- humate-p intravenous solution
reconstituted 1000-2400 unit, 500-1200
unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira

Products Affected

- humira subcutaneous prefilled syringe kit
10 mg/0.1ml, 20 mg/0.2ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira

Products Affected

- humira subcutaneous prefilled syringe kit
10 mg/0.2ml, 20 mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira

Products Affected

- humira subcutaneous prefilled syringe kit
40 mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira

Products Affected

- humira subcutaneous prefilled syringe kit
40 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pediatric Crohns Start

Products Affected

- humira pediatric crohns start
subcutaneous prefilled syringe kit 40
mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pediatric Crohns Start

Products Affected

- humira pediatric crohns start
subcutaneous prefilled syringe kit 80
mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pediatric Crohns Start

Products Affected

- humira pediatric crohns start
subcutaneous prefilled syringe kit 80
mg/0.8ml & 40mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pen

Products Affected

- humira pen subcutaneous pen-injector kit
40 mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pen

Products Affected

- humira pen subcutaneous pen-injector kit
40 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pen-CD/UC/HS Starter

Products Affected

- humira pen-cd/uc/hs starter subcutaneous pen-injector kit 40 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pen-CD/UC/HS Starter

Products Affected

- humira pen-cd/uc/hs starter subcutaneous pen-injector kit 80 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pen-Ps/UV Starter

Products Affected

- humira pen-ps/uv starter subcutaneous pen-injector kit 40 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Humira Pen-Ps/UV Starter

Products Affected

- humira pen-ps/uv starter subcutaneous pen-injector kit 80 mg/0.8ml & 40mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hyalgan

Products Affected

- hyalgan

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hycamtin

Products Affected

- hycamtin oral

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hydrocod Polst-CPM Polst ER

Products Affected

- *hydrocod polst-cpm polst er oral suspension extended release*

QL Criteria	120 ML Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hydrocodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen oral solution*
2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	180 MLS Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hydrocodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	9 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hydrocodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen oral tablet 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hydrocodone-Ibuprofen

Products Affected

- *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	5 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

HYDRomorphone HCl

Products Affected

- *hydromorphone hcl oral liquid*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	22 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

HYDRomorphone HCl

Products Affected

- *hydromorphone hcl oral tablet 2 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	11 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

HYDRomorphone HCl

Products Affected

- *hydromorphone hcl oral tablet 4 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	5 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

HYDRomorphone HCl

Products Affected

- *hydromorphone hcl oral tablet 8 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

HYDRomorphone HCl

Products Affected

- *hydromorphone hcl rectal*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 suppositories Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

HYDRomorphone HCl ER

Products Affected

- *hydromorphone hcl er*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

HYDROXYprogesterone Caproate

Products Affected

- *hydroxyprogesterone caproate intramuscular oil*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/hydroxyprogesterone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hymovis

Products Affected

- hymovis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hyqvia

Products Affected

- hyqvia

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Hysingla ER

Products Affected

- hysingla er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

QL Criteria	1 tablet Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ibrance

Products Affected

- ibrance

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	21 EA Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ibudone

Products Affected

- ibudone oral tablet 10-200 mg
- *ibudone oral tablet 5-200 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	5 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Iclusig

Products Affected

- iclusig oral tablet 15 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Iclusig

Products Affected

- iclusig oral tablet 45 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Idelvion

Products Affected

- idelvion

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

IDHIFA

Products Affected

- idhifa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/I/dhifa.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ilaris

Products Affected

- ilaris subcutaneous solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Ilaris.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ilumya

Products Affected

- ilumya

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Ilumya.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 84 Days
Notes/References	
Revision Date	Prior Authorization: September 05, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imatinib Mesylate

Products Affected

- *imatinib mesylate oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imatinib Mesylate

Products Affected

- *imatinib mesylate oral tablet 400 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imbruvica

Products Affected

- imbruvica oral capsule 70 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imbruvica

Products Affected

- imbruvica oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imiquimod

Products Affected

- *imiquimod external*

QL Criteria	48 packets Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imitrex

Products Affected

- imitrex nasal

QL Criteria	6 sprays Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imitrex

Products Affected

- imitrex oral

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imitrex

Products Affected

- imitrex subcutaneous

QL Criteria	10 vials/30 days Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imitrex STATdose Refill

Products Affected

- imitrex statdose refill subcutaneous solution cartridge

QL Criteria	10 cart/30 days Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Imitrex STATdose System

Products Affected

- imitrex statdose system subcutaneous solution auto-injector

QL Criteria	10 cart/30 days Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Impavido

Products Affected

- impavido

PA Criteria	Criteria Details
Covered Uses	Leishmaniasis
Exclusion Criteria	Known or suspected pregnancy
Required Medical Information	A documented diagnosis of any of the following leishmaniasis infections: Visceral leishmaniasis due to <i>Leishmania donovani</i> , Cutaneous leishmaniasis due to <i>Leishmania braziliensis</i> , <i>Leishmania guyanensis</i> , and <i>Leishmania panamensis</i> , or Mucosal leishmaniasis due to <i>Leishmania braziliensis</i>
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	28 days
Other Criteria	
QL Criteria	84 capsules Per 28 days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 16, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Impoyz

Products Affected

- impoyz

QL Criteria	4 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

In Touch Blood Glucose Test

Products Affected

- in touch blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Increlex

Products Affected

- increlex

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Increlex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Inderal XL

Products Affected

- Inderal XL oral capsule extended release 24 hour 80 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Indomethacin

Products Affected

- *indomethacin oral*

QL Criteria	3 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Infinity Blood Glucose Test

Products Affected

- infinity blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Inflectra

Products Affected

- inflectra

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Inflectra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ingrezza

Products Affected

- ingrezza oral capsule 40 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Ingrezza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ingrezza

Products Affected

- ingrezza oral capsule 80 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Ingrezza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Inlyta

Products Affected

- inlyta

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

InnoPran XL

Products Affected

- innopran xl oral capsule extended release
24 hour 120 mg

QL Criteria	1 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

InnoPran XL

Products Affected

- innopran xl oral capsule extended release
24 hour 80 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Intelligence

Products Affected

- intelligence oral tablet 100 mg, 25 mg

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Intelligence

Products Affected

- intelligence oral tablet 200 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Intermezzo

Products Affected

- intermezzo

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Intrarosa

Products Affected

- intrarosa

QL Criteria	1 insert Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Intron A

Products Affected

- intron a

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Intron.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Intuniv

Products Affected

- intuniv

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Invega

Products Affected

- invega oral tablet extended release 24 hour
1.5 mg, 3 mg, 9 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Schizoaffective disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia or Schizoaffective disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Schizophrenia or Schizoaffective disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Invega

Products Affected

- invega oral tablet extended release 24 hour
6 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Schizoaffective disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia or Schizoaffective disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Schizophrenia or Schizoaffective disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Invokamet

Products Affected

- invokamet

QL Criteria	2 tablets Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Invokamet XR

Products Affected

- invokamet xr

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Invokana

Products Affected

- invokana

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ipratropium Bromide

Products Affected

- *ipratropium bromide nasal*

QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Irbesartan

Products Affected

- *irbesartan*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Iressa

Products Affected

- iressa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Iressa.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Isentress

Products Affected

- isentress oral tablet

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Isentress

Products Affected

- isentress oral tablet chewable

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Isentress HD

Products Affected

- isentress hd

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ISOtretinoin

Products Affected

- *isotretinoin oral*

PA Criteria	Criteria Details
Covered Uses	Severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member is enrolled in the FDA iPLEDGE program and, because of significant adverse reactions associated with its use, should be reserved for patients with multiple severe nodular acne who are unresponsive to conventional therapy, including topical acne products and systemic antibiotics. Treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Itraconazole

Products Affected

- *itraconazole oral capsule*

QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ixinity

Products Affected

- ixinity

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jadenu

Products Affected

- jadenu

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Anitdotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jadenu Sprinkle

Products Affected

- jadenu sprinkle

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Anitdotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jakafi

Products Affected

- jakafi oral tablet 10 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jakafi

Products Affected

- jakafi oral tablet 15 mg, 20 mg, 25 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Janumet

Products Affected

- janumet

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Janumet XR

Products Affected

- janumet xr oral tablet extended release 24 hour 100-1000 mg, 50-500 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet XR

Products Affected

- janumet xr oral tablet extended release 24 hour 50-1000 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Januvia

Products Affected

- januvia

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jardiance

Products Affected

- jardiance

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jentaducto

Products Affected

- jentaducto

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jentaduetto XR

Products Affected

- jentaduetto xr oral tablet extended release
24 hour 2.5-1000 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jentaducto XR

Products Affected

- jentaducto xr oral tablet extended release
24 hour 5-1000 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jetrea

Products Affected

- jetrea intravitreal solution 0.375 mg/0.3ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jevtana

Products Affected

- jevtana

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/jevtana.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jivi

Products Affected

- jivi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jublia

Products Affected

- jublia

PA Criteria	Criteria Details
Covered Uses	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Failure of an adequate trial of one systemic oral alternative is terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail), OR If member has hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or is female and is pregnant and/or breastfeeding. (No trial needed)
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Juluca

Products Affected

- Juluca

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Juxtapid

Products Affected

- juxtapid

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Antilipidemic_Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Jynarque

Products Affected

- jynarque

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Jynarque.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kadian

Products Affected

- kadian oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 200 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kalbitor

Products Affected

- kalbitor

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kalydeco

Products Affected

- kalydeco oral packet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kalydeco

Products Affected

- kalydeco oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kanuma

Products Affected

- kanuma

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kapvay

Products Affected

- kapvay oral tablet extended release 12 hour

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kazano

Products Affected

- kazano

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kepivance

Products Affected

- kepivance

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Keppra XR

Products Affected

- keppra xr oral tablet extended release 24 hour 500 mg

QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Keppra XR

Products Affected

- keppra xr oral tablet extended release 24 hour 750 mg

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kerydin

Products Affected

- kerydin

PA Criteria	Criteria Details
Covered Uses	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Failure of an adequate trial of one systemic oral alternative is terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail), OR If member has hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or is female and is pregnant and/or breastfeeding. (No trial needed)
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ketoconazole

Products Affected

- *ketoconazole external foam*

QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ketoconazole

Products Affected

- *ketoconazole oral*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

QL Criteria	20 tablets Per 5 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Keveyis

Products Affected

- keveyis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/carb onic_anhydrase_inhibitor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kevzara

Products Affected

- kevozara

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Kevzara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Khedezla

Products Affected

- khedezla

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 TB24 Per 1 DAYS
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kineret

Products Affected

- kineret subcutaneous solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Kineret.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kisqali 200 Dose

Products Affected

- kisqali 200 dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOP/L/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kisqali 400 Dose

Products Affected

- kisqali 400 dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOP/L/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kisqali 600 Dose

Products Affected

- kisqali 600 dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOP/L/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kisqali Femara 200 Dose

Products Affected

- kisqali femara 200 dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOP/L/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kisqali Femara 400 Dose

Products Affected

- kisqali femara 400 dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kisqali Femara 600 Dose

Products Affected

- kisqali femara 600 dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOP/L/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kitabis Pak

Products Affected

- kitabis pak

QL Criteria	10 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Klofensaid II

Products Affected

- klofensaid ii

QL Criteria	10 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Klor-Con

Products Affected

- klor-con oral packet 20 meq

QL Criteria	5 packs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Koate

Products Affected

- koate

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Koate-DVI

Products Affected

- koate-dvi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kogenate FS

Products Affected

- kogenate fs

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kombiglyze XR

Products Affected

- kombiglyze xr oral tablet extended release
24 hour 2.5-1000 mg

QL Criteria	2 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kombiglyze XR

Products Affected

- kombiglyze xr oral tablet extended release
24 hour 5-1000 mg, 5-500 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Korlym

Products Affected

- korlym

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/anti-diabetic-agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kovaltry

Products Affected

- kovaltry

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kristalose

Products Affected

- kristalose

QL Criteria	60 packets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kroger Blood Glucose Test

Products Affected

- *kroger blood glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kroger Test

Products Affected

- *kroger test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Krystexxa

Products Affected

- krystexxa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gout.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kuvan

Products Affected

- kuvan

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Kynamro

Products Affected

- kynamro subcutaneous solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Antilipidemic_Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 SOLN Per 30 DAYs
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lactulose

Products Affected

- *lactulose oral packet*

QL Criteria	2 packets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LaMICtal ODT

Products Affected

- lamictal odt oral tablet dispersible 100 mg,
200 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal ODT

Products Affected

- lamictal odt oral tablet dispersible 25 mg

QL Criteria	6 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LaMICtal ODT

Products Affected

- lamictal odt oral tablet dispersible 50 mg

QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LaMICtal XR

Products Affected

- lamictal xr oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LaMICtal XR

Products Affected

- lamictal xr oral tablet extended release 24 hour 200 mg

QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal XR

Products Affected

- lamictal xr oral tablet extended release 24 hour 250 mg, 300 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LamoTRIGine

Products Affected

- *lamotrigine oral tablet dispersible 100 mg, 200 mg*

QL Criteria	2 TAB Per 1 DAILY
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LamoTRIGine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

QL Criteria	6 TAB Per 1 DAILY
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LamoTRIGine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

QL Criteria	3 TAB Per 1 DAILY
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIGine ER

Products Affected

- *lamotrigine er oral tablet extended release*
24 hour 100 mg, 25 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LamoTRIGine ER

Products Affected

- *lamotrigine er oral tablet extended release*
24 hour 200 mg

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIGine ER

Products Affected

- *lamotrigine er oral tablet extended release*
24 hour 250 mg, 300 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LamoTRIGine ER

Products Affected

- *lamotrigine er oral tablet extended release*
24 hour 50 mg

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release 15 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release 30 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lansoprazole

Products Affected

- *lansoprazole oral tablet dispersible*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Latuda

Products Affected

- latuda oral tablet 120 mg, 20 mg, 40 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Latuda

Products Affected

- latuda oral tablet 80 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lazanda

Products Affected

- lazanda nasal solution 100 mcg/act, 400 mcg/act

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
QL Criteria	15 bottles Per 1 fill
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Lazanda

Products Affected

- lazanda nasal solution 300 mcg/act

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
QL Criteria	4 bottles Per 30 days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Leflunomide

Products Affected

- *leflunomide oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lemtrada

Products Affected

- lemtrada

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Lemtrada.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 ml Per 365 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 10 MG Daily Dose

Products Affected

- lenvima 10 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 12 MG Daily Dose

Products Affected

- lenvima 12 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 14 MG Daily Dose

Products Affected

- lenvima 14 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 18 MG Daily Dose

Products Affected

- lenvima 18 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 fill
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 20 MG Daily Dose

Products Affected

- lenvima 20 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 24 MG Daily Dose

Products Affected

- lenvima 24 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 4 MG Daily Dose

Products Affected

- lenvima 4 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lenvima 8 MG Daily Dose

Products Affected

- lenvima 8 mg daily dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 fill
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lescol

Products Affected

- lescol oral capsule 20 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lescol XL

Products Affected

- lescol xl

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Letairis

Products Affected

- letairis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Leukine

Products Affected

- leukine intravenous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Leuprolide Acetate

Products Affected

- *leuprolide acetate injection*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LevETIRAcetam ER

Products Affected

- *levetiracetam er oral tablet extended release*
24 hour 500 mg

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

LevETIRAcetam ER

Products Affected

- *levetiracetam er oral tablet extended release*
24 hour 750 mg

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levorphanol Tartrate

Products Affected

- *levorphanol tartrate oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Levulan Kerastick

Products Affected

- levulan kerastick

QL Criteria	1 stick Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lexapro

Products Affected

- lexapro oral tablet 10 mg

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lexapro

Products Affected

- lexapro oral tablet 20 mg, 5 mg

QL Criteria	1 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lialda

Products Affected

- lialda

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Next Generation Test

Products Affected

- liberty next generation test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Liberty Test

Products Affected

- *liberty test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Librax

Products Affected

- librax

PA Criteria	Criteria Details
Covered Uses	To control emotional and somatic factors in gastrointestinal disorders or as adjunctive therapy for the treatment of peptic ulcer, irritable bowel syndrome or acute enterocolitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Irritable bowel syndrome, Acute enterocolitis, Peptic ulcer or is being used to control emotional and somatic factors in gastrointestinal disorders.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lidocaine

Products Affected

- *lidocaine external ointment*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, sensitivity to amide-type local anesthetics or any other component of the product, planned use on large surface area of the body as this can lead to increased toxicity, planned area of application includes severely traumatized skin (e.g., mucosal or skin abrasion, eczema, burns), the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), or if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for temporary anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>*Topical lidocaine ointment is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Approval can made up to an additional 50gms per 30 days. Higher additional quantities are not approvable *FOR ADULTS: A single application should not exceed 5 g of Lidocaine Ointment 5%, containing 250 mg of lidocaine base (equivalent chemically to approximately 300 mg of lidocaine hydrochloride). This is roughly equivalent to squeezing a six (6) inch length of ointment from the tube. In a 70 kg adult this dose equals 3.6 mg/kg (1.6 mg/lb) lidocaine base. No more than one-half tube, approximately 17-20 g of ointment or 850-1000 mg lidocaine base, should be administered in any one day. FOR CHILDREN: For children less than ten years who have a normal lean body mass and a normal lean body development, the maximum dose may be determined by the application of one of the standard pediatric drug formulas (e.g., Clark's rule). For example a child of five years weighing 50 lbs., the dose of lidocaine should not exceed 75-100 mg when calculated according to Clark's rule. In any case, the maximum amount of lidocaine administered should not exceed 4.5 mg/kg (2.0 mg/lb) of body weight ***Lidocaine toxicity resulting from transcutaneous absorption is theoretically possible. Signs and symptoms of systemic lidocaine toxicity include CNS excitation and/or depression, nervousness, confusion, dizziness, tinnitus, blurred or double vision, vomiting, twitching, tremors, seizures, unconsciousness, respiratory depression, bradycardia, hypotension, and cardiopulmonary arrest. If there is suspicion of lidocaine-related systemic toxicity, check lidocaine blood concentrations</p>
QL Criteria	50 GM Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Lidocaine

Products Affected

- *lidocaine external patch 5%*

PA Criteria	Criteria Details
Covered Uses	Neuropathic pain (i.e. post herpetic neuralgia).
Exclusion Criteria	
Required Medical Information	A documented diagnosis of neuropathic pain (i.e. post herpetic neuralgia).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	3 patches Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: September 01, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lidocaine PAK

Products Affected

- *lidocaine pak*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, sensitivity to amide-type local anesthetics or any other component of the product, planned use on large surface area of the body as this can lead to increased toxicity, planned area of application includes severely traumatized skin (e.g., mucosal or skin abrasion, eczema, burns), the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), or if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for temporary anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>*Topical lidocaine ointment is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Approval can made up to an additional 50gms per 30 days. Higher additional quantities are not approvable *FOR ADULTS: A single application should not exceed 5 g of Lidocaine Ointment 5%, containing 250 mg of lidocaine base (equivalent chemically to approximately 300 mg of lidocaine hydrochloride). This is roughly equivalent to squeezing a six (6) inch length of ointment from the tube. In a 70 kg adult this dose equals 3.6 mg/kg (1.6 mg/lb) lidocaine base. No more than one-half tube, approximately 17-20 g of ointment or 850-1000 mg lidocaine base, should be administered in any one day. FOR CHILDREN: For children less than ten years who have a normal lean body mass and a normal lean body development, the maximum dose may be determined by the application of one of the standard pediatric drug formulas (e.g., Clark's rule). For example a child of five years weighing 50 lbs., the dose of lidocaine should not exceed 75-100 mg when calculated according to Clark's rule. In any case, the maximum amount of lidocaine administered should not exceed 4.5 mg/kg (2.0 mg/lb) of body weight ***Lidocaine toxicity resulting from transcutaneous absorption is theoretically possible. Signs and symptoms of systemic lidocaine toxicity include CNS excitation and/or depression, nervousness, confusion, dizziness, tinnitus, blurred or double vision, vomiting, twitching, tremors, seizures, unconsciousness, respiratory depression, bradycardia, hypotension, and cardiopulmonary arrest. If there is suspicion of lidocaine-related systemic toxicity, check lidocaine blood concentrations</p>
QL Criteria	50 GM Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Lidocaine-Prilocaine

Products Affected

- *lidocaine-prilocaine external cream*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 30 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 30 grams every 30 days, there must be a documented temporary need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, Sensitivity to amide-type local anesthetics or any other component of the product, Planned use on large surface area of the body or for a period of time over 3 hours as this can lead to increased toxicity, the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), Use in situations where the drug may migrate into the middle ear, beyond the tympanic membrane, History of methemoglobinemia, or if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Other Criteria	*Topical lidocaine/prilocaine cream is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Up to an additional 30 grams per 30 days. Higher additional quantities are not approvable.
QL Criteria	30 GM Per 30 Days
Notes/References	
Revision Date	Prior Authorization: October 05, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lidocaine-Tetracaine

Products Affected

- *lidocaine-tetracaine*

QL Criteria	30 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lidoderm

Products Affected

- lidoderm

PA Criteria	Criteria Details
Covered Uses	Neuropathic pain (i.e. post herpetic neuralgia).
Exclusion Criteria	
Required Medical Information	A documented diagnosis of neuropathic pain (i.e. post herpetic neuralgia).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	3 patches Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Linezolid

Products Affected

- *linezolid oral suspension reconstituted*

QL Criteria	150 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Linezolid

Products Affected

- *linezolid oral tablet*

QL Criteria	28 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Linzess

Products Affected

- linzess oral capsule 145 mcg, 290 mcg

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lipitor

Products Affected

- lipitor

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lipofen

Products Affected

- lipofen

QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Livalo

Products Affected

- livalo

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lokelma

Products Affected

- lokelma

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperkalemia
Exclusion Criteria	
Required Medical Information	The member is greater than or equal to 18 years of age, AND has hyperkalemia (serum potassium level of 5.0mEq/L to less than 6.5 mEq/L), AND has been counseled to report any incidence of edema to physician and to adjust dietary sodium intake if necessary; AND has been counseled to take all other oral medications 2 hours before or 2 hours after Lokelma; AND Lokelma will not be used as an emergency treatment for life-threatening hyperkalemia; AND the member is following a low potassium diet (less than or equal to 3 grams per day).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Reauthorization criteria: Use of Lokelma has been effective in treating hyperkalemia (e.g. current serum potassium level is lower than the pretreatment baseline serum potassium level) and the member continues to require treatment for hyperkalemia; AND continues to monitor for edema and adjust dietary sodium when needed; AND the member continues to follow a low potassium diet (less than or equal to 3 grams per day).
Notes/References	
Revision Date	Prior Authorization: September 19, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Lonhala Magnair Refill Kit

Products Affected

- lonhala magnair refill kit

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lonhala Magnair Starter Kit

Products Affected

- lonhala magnair starter kit

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 kit Per 1 year
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lonsurf

Products Affected

- lonsurf oral tablet 15-6.14 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	100 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lonsurf

Products Affected

- lonsurf oral tablet 20-8.19 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	80 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lorcet

Products Affected

- lorcet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Lorcet HD

Products Affected

- lorcet hd

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	9 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lorcet Plus

Products Affected

- lorcet plus oral tablet 7.5-325 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Losartan Potassium

Products Affected

- *losartan potassium oral tablet 25 mg, 50 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lotronex

Products Affected

- lotronex

PA Criteria	Criteria Details
Covered Uses	Severe diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis in a female patient of severe diarrhea-predominant irritable bowel syndrome (IBS) with either frequent and severe abdominal pain/discomfort, frequent urgency or fecal incontinence, or disability or restriction of daily activities due to IBS, and the patient has chronic IBS symptoms generally lasting 6 months or longer, and anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 30, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lovastatin

Products Affected

- *lovastatin*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lovaza

Products Affected

- lovaza

QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lovenox

Products Affected

- lovenox

QL Criteria	2 syringes Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lucemyra

Products Affected

- lucemyra

QL Criteria	192 tablets Per 3 courses in 1 years
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: October 09, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lucentis

Products Affected

- lucentis intravitreal solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/EYE/opthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Luliconazole

Products Affected

- *luliconazole*

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 29, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lumigan

Products Affected

- lumigan ophthalmic solution 0.01 %

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lumizyme

Products Affected

- lumizyme

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lunesta

Products Affected

- lunesta

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lupaneta Pack

Products Affected

- lupaneta pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lupron Depot (1-Month)

Products Affected

- lupron depot (1-month)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lupron Depot (3-Month)

Products Affected

- lupron depot (3-month)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lupron Depot (4-Month)

Products Affected

- lupron depot (4-month)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lupron Depot (6-Month)

Products Affected

- lupron depot (6-month)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lupron Depot-Ped (1-Month)

Products Affected

- lupron depot-ped (1-month)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lupron Depot-Ped (3-Month)

Products Affected

- lupron depot-ped (3-month)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Luzu

Products Affected

- luzu

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lynparza

Products Affected

- lynparza oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lyrica CR

Products Affected

- lyrica cr oral tablet extended release 24 hour 165 mg, 82.5 mg

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

Lyrica CR

Products Affected

- lyrica cr oral tablet extended release 24 hour 330 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Lysteda

Products Affected

- lysteda

QL Criteria	30 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Macugen

Products Affected

- macugen

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/EYE/opththalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Makena

Products Affected

- makena intramuscular

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/hydroxyprogesterone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Makena

Products Affected

- makena subcutaneous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/hydroxyprogesterone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	21 syringes Per 365 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: April 16, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Maprotiline HCl

Products Affected

- *maprotiline hcl*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Marinol

Products Affected

- marinol

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Matzim LA

Products Affected

- *matzim la oral tablet extended release 24 hour 180 mg, 300 mg, 360 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Matzim LA

Products Affected

- *matzim la oral tablet extended release 24 hour 240 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mavyret

Products Affected

- mavyret

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Mavyret.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Maxalt

Products Affected

- maxalt oral tablet 10 mg

QL Criteria	12 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Maxalt-MLT

Products Affected

- maxalt-mlt

QL Criteria	12 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mefenamic Acid

Products Affected

- *mefenamic acid oral*

QL Criteria	30 capsules Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Meijer Blood Glucose Test

Products Affected

- *meijer blood glucose test*

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Meijer TRUEtest Test

Products Affected

- meijer truetest test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Meijer TRUEtrack Test

Products Affected

- meijer truetrack test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mekinist

Products Affected

- mekinist oral tablet 0.5 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mekinist

Products Affected

- mekinist oral tablet 2 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mektovi

Products Affected

- mektovi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Mektovi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Memantine HCl ER

Products Affected

- *memantine hcl er*

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Menopur

Products Affected

- menopur

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/inferility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Menostar

Products Affected

- menostar

QL Criteria	1 box (4 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Meperidine HCl

Products Affected

- *meperidine hcl oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	90 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Meperidine HCl

Products Affected

- *meperidine hcl oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	9 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Meperidine HCl

Products Affected

- *meperidine hcl oral tablet 50 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	18 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mephyton

Products Affected

- mephyton

QL Criteria	25 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 1.2 gm*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 800 mg*

QL Criteria	6 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Metadate ER

Products Affected

- metadate er oral tablet extended release 20 mg

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MetFORMIN HCl ER (MOD)

Products Affected

- *metformin hcl er (mod) oral tablet extended release 24 hour 1000 mg*

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MetFORMIN HCl ER (MOD)

Products Affected

- *metformin hcl er (mod) oral tablet
extended release 24 hour 500 mg*

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MetFORMIN HCl ER (OSM)

Products Affected

- *metformin hcl er (osm) oral tablet extended release 24 hour 1000 mg*

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MetFORMIN HCl ER (OSM)

Products Affected

- *metformin hcl er (osm) oral tablet extended release 24 hour 500 mg*

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels greater than or equal to 1.5 mg/dL [males], greater than or equal to 1.4 mg/dL [females] or abnormal creatinine clearance). Known hypersensitivity to metformin hydrochloride. Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma.
Required Medical Information	A documented diagnosis of type 2 diabetes, medication is being use as adjunctive to diet and exercise, an HbA1c greater than or equal to 6.5%, and member has had a trial of 12 weeks each of metformin immediate-release and of metformin extended-release (Glucophage XR) with a maximum dose of 2000mg of each, or requestor must provide medical records (e.g., chart notes, laboratory values) which documents inadequate response to metformin IR and metformin ER (HbA1c results must be provided to show failure based on patients goal), or requestor provides medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize adverse effects such as dose reduction and continued inadequate response documented by HbA1c results showing failure to patients goals.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methadone HCl

Products Affected

- *methadone hcl oral concentrate*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methadone HCl

Products Affected

- *methadone hcl oral solution 10 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	15 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methadone HCl

Products Affected

- *methadone hcl oral solution 5 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	30 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methadone HCl

Products Affected

- *methadone hcl oral tablet 10 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Methadone HCl

Products Affected

- *methadone hcl oral tablet 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methadone HCl Intensol

Products Affected

- *methadone hcl intensol*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 MLS Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Methadose

Products Affected

- methadose oral concentrate 10 mg/ml

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: December 27, 2017</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methadose Sugar-Free

Products Affected

- methadose sugar-free

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methamphetamine HCl

Products Affected

- *methamphetamine hcl*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 tablets Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methergine

Products Affected

- methergine oral

QL Criteria	4 tablets Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylin

Products Affected

- methylin oral solution 10 mg/5ml

QL Criteria	30 MLS Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylin

Products Affected

- methylin oral solution 5 mg/5ml

QL Criteria	60 MLS Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral solution 10 mg/5ml*

QL Criteria	30 milliliters Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral solution 5 mg/5ml*

QL Criteria	60 milliliters Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

QL Criteria	6 tablet Per 1 Day
Notes/ References	Annual Review: 10/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet chewable*

QL Criteria	6 tablets Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 10 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 18 mg, 27 mg, 54 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 20 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 36 mg*

QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 72 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 24 hour 36 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule
extended release 24 hour 10 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule*
extended release 24 hour 20 mg, 40 mg

QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule
extended release 24 hour 30 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule
extended release 24 hour 60 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 50 mg*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 200 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 25 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Metoprolol-HCTZ ER

Products Affected

- *metoprolol-hctz er oral tablet extended release 24 hour 100-12.5 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metoprolol-HCTZ ER

Products Affected

- *metoprolol-hctz er oral tablet extended release 24 hour 25-12.5 mg, 50-12.5 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mevacor

Products Affected

- mevacor oral tablet 40 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Miacalcin

Products Affected

- miacalcin injection

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Miacalcin

Products Affected

- miacalcin nasal

QL Criteria	1 bottle Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Micardis

Products Affected

- micardis

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Micardis HCT

Products Affected

- micardis hct

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Microdot Test

Products Affected

- microdot test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Miglustat

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Migranal

Products Affected

- migranal

QL Criteria	9 MLS Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mimvey

Products Affected

- *mimvey*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Minivelle

Products Affected

- minivelle

QL Criteria	8 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mirapex ER

Products Affected

- mirapex er

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mircera

Products Affected

- mircera injection solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mirtazapine

Products Affected

- *mirtazapine oral*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mirvaso

Products Affected

- mirvaso

PA Criteria	Criteria Details
Covered Uses	Topical treatment of persistent (nontransient) facial erythema associated with rosacea in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of persistent (nontransient) facial erythema associated with rosacea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mitigare

Products Affected

- mitigate

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Modafinil

Products Affected

- *modafinil oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with modafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Modafinil

Products Affected

- *modafinil oral tablet 200 mg*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with modafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Monoclalte-P

Products Affected

- monoclate-p intravenous kit 1000 unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mononine

Products Affected

- mononine intravenous solution reconstituted 1000 unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Monovisc

Products Affected

- monovisc

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Montelukast Sodium

Products Affected

- *montelukast sodium oral packet*

QL Criteria	1 pack Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Montelukast Sodium

Products Affected

- *montelukast sodium oral tablet*
- *montelukast sodium oral tablet chewable*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MorphaBond ER

Products Affected

- morphabond er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Morphine Sulfate

Products Affected

- morphine sulfate oral solution 10 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	45 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate

Products Affected

- morphine sulfate oral solution 20 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	22.5 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate

Products Affected

- *morphine sulfate oral tablet 15 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate

Products Affected

- morphine sulfate oral tablet 30 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Morphine Sulfate

Products Affected

- *morphine sulfate rectal suppository 10 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 suppositories Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Morphine Sulfate

Products Affected

- morphine sulfate rectal suppository 20 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 suppositories Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate

Products Affected

- morphine sulfate rectal suppository 30 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 suppositories Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate (Concentrate)

Products Affected

- morphine sulfate (concentrate) oral solution 100 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.</p>
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	4.5 MLS Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate (Concentrate)

Products Affected

- *morphine sulfate (concentrate) oral solution 20 mg/ml*

QL Criteria	4.5 mls Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: July 31, 2018

Morphine Sulfate ER

Products Affected

- morphine sulfate er oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.</p>
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral capsule extended release 24 hour 40 mg*

PA Criteria	Criteria Details
Covered Uses	Moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time.
Exclusion Criteria	
Required Medical Information	Documented diagnosis of pain severe enough to require daily, around the clock, long-term opioid treatment and for which alternative treatment options are inadequate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate ER

Products Affected

- morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Morphine Sulfate ER

Products Affected

- morphine sulfate er oral tablet extended release 15 mg, 30 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Morphine Sulfate ER Beads

Products Affected

- *morphine sulfate er beads*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Movantik

Products Affected

- movantik

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mozobil

Products Affected

- mozobil

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Mozobil.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MS Contin

Products Affected

- ms contin oral tablet extended release 100 mg, 200 mg, 60 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MS Contin

Products Affected

- ms contin oral tablet extended release 15 mg, 30 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Mulpleta

Products Affected

- mulpleta

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Dop telet.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 /day for 7 days Per 30 days
Notes/References	
Revision Date	Prior Authorization: June 27, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Multaq

Products Affected

- multaq

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mupirocin

Products Affected

- *mupirocin external*

QL Criteria	60 gram Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mupirocin Calcium

Products Affected

- *mupirocin calcium*

QL Criteria	60 gram Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Myalept

Products Affected

- myalept

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.5 VIAL Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mydayis

Products Affected

- mydayis

PA Criteria	Criteria Details
Covered Uses	Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 13 years and older
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
Age Restrictions	13 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD in patients 13 years and older AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

MyGlucoHealth Test

Products Affected

- myglucohealth test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Myobloc

Products Affected

- myobloc intramuscular solution 2500 unit/0.5ml, 5000 unit/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Myorisan

Products Affected

- *myorisan oral capsule 10 mg, 20 mg, 40 mg* • myorisan oral capsule 30 mg

PA Criteria	Criteria Details
Covered Uses	Severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member is enrolled in the FDA iPLEDGE program and, because of significant adverse reactions associated with its use, should be reserved for patients with multiple severe nodular acne who are unresponsive to conventional therapy, including topical acne products and systemic antibiotics. Treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Myrbetriq

Products Affected

- myrbetriq

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Mytesi

Products Affected

- mytesi

PA Criteria	Criteria Details
Covered Uses	Non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy
Exclusion Criteria	
Required Medical Information	Covered for adult members who have a documented diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month and who are currently stable on anti-retroviral therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Naftifine HCl

Products Affected

- *naftifine hcl external cream 2 %*

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Naftin

Products Affected

- naftin external cream 2 %
- naftin external gel

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naglazyme

Products Affected

- naglazyme

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nalocet

Products Affected

- *nalocet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: July 16, 2018</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Namenda

Products Affected

- namenda oral tablet

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Namenda Titration Pak

Products Affected

- namenda titration pak

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Namenda XR

Products Affected

- namenda xr

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Namenda XR Titration Pack

Products Affected

- namenda xr titration pack

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Namzarin

Products Affected

- namzarin

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Naratriptan HCl

Products Affected

- *naratriptan hcl*

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Narcan

Products Affected

- narcan

QL Criteria	30 days maximum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nasacort Allergy 24HR

Products Affected

- nasacort allergy 24hr

QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nasacort Allergy 24HR Children

Products Affected

- nasacort allergy 24hr children

QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nasal Allergy 24 Hour

Products Affected

- *nasal allergy 24 hour*

QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Natesto

Products Affected

- natesto

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	3 pumps Per 30 Days
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Natpara

Products Affected

- natpara

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ctg Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nerlynx

Products Affected

- nerlynx

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Nerlynx.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nesina

Products Affected

- nesina oral tablet 12.5 mg, 6.25 mg

QL Criteria	1 tablets Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nesina

Products Affected

- nesina oral tablet 25 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Neulasta

Products Affected

- neulasta subcutaneous solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Neupogen

Products Affected

- neupogen injection solution 300 mcg/ml, 480 mcg/1.6ml
- neupogen injection solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Neupro

Products Affected

- neupro

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neurontin

Products Affected

- neurontin oral capsule
- neurontin oral tablet

QL Criteria	6 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Neutek 2Tek Glucose/Pressure

Products Affected

- neutek 2tek glucose/pressure

QL Criteria	1 meter Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Neutek 2Tek Test

Products Affected

- neutek 2tek test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nevirapine ER

Products Affected

- *nevirapine er oral tablet extended release 24 hour 100 mg*

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nevirapine ER

Products Affected

- *nevirapine er oral tablet extended release 24 hour 400 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

NexAVAR

Products Affected

- nexavar

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

NexIUM

Products Affected

- nexium oral capsule delayed release 40 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

NexIUM

Products Affected

- nexium oral packet

QL Criteria	1 pack Per 1 day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexIUM 24HR

Products Affected

- nexium 24hr

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Next Choice One Dose

Products Affected

- *next choice one dose*

QL Criteria	1 tablet Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicoderm CQ

Products Affected

- nicoderm cq

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nicorelief

Products Affected

- *nicorelief mouth/throat gum*

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicorette

Products Affected

- nicorette mouth/throat gum

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nicotine

Products Affected

- *nicotine transdermal patch 24 hour*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotine Step 1

Products Affected

- *nicotine step 1*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nicotine Step 2

Products Affected

- *nicotine step 2*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotine Step 3

Products Affected

- *nicotine step 3*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nicotrol

Products Affected

- nicotrol

QL Criteria	3 boxes-504 ctrtg Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nicotrol NS

Products Affected

- nicotrol ns

QL Criteria	4 bottles Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nifedical XL

Products Affected

- *nifedical xl oral tablet extended release 24 hour 60 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NIFEdipine ER

Products Affected

- *nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

NIFEdipine ER

Products Affected

- *nifedipine er oral tablet extended release 24 hour 60 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NIFEdipine ER Osmotic Release

Products Affected

- *nifedipine er osmotic release oral tablet*
extended release 24 hour 30 mg, 90 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

NIFEdipine ER Osmotic Release

Products Affected

- *nifedipine er osmotic release oral tablet*
extended release 24 hour 60 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ninlaro

Products Affected

- ninlaro

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release*
24 hour 17 mg, 20 mg, 34 mg, 40 mg, 8.5 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release*
24 hour 30 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nityr

Products Affected

- nityr

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nivestym

Products Affected

- nivestym

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nocdurna

Products Affected

- nocdurna

PA Criteria	Criteria Details
<p>Covered Uses</p>	<p>Initial Criteria Treatment of nocturia in adult patients with a documented diagnosis of nocturnal polyuria that meet all of the following:</p> <ol style="list-style-type: none"> 1. Diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection where night-time urine production exceeds one-third of the 24-hour urine production, AND 2. Patient awakens at least 2 times per night to void, AND 3. Other causes of nocturia, such as excessive fluid intake prior to bedtime, have been ruled out, AND 4. Patient does not have an increased risk of severe hyponatremia, such as patients with a history of hyponatremia, excessive fluid intake, polydipsia, illnesses that can cause fluid or electrolyte imbalances (such as gastroenteritis, salt-wasting nephropathies, or systemic infection), renal impairment with estimated glomerular filtration rate (eGFR) below 50 mL/min/1.73 m², known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion, and in those using loop diuretics or systemic or inhaled glucocorticoids, AND 5. Patient does not have heart failure, AND 6. Patient does not have uncontrolled hypertension, AND 7. Patient is not pregnant, AND 8. Serum sodium concentration is normal before starting or resuming Nocdurna, AND 9. Serum sodium concentration will be within 1 week and approximately 1 month of initiating Nocdurna, and periodically thereafter. <p>Continuation Criteria Nocdurna will be continued for 3 month intervals for patients with a documented diagnosis of nocturnal polyuria that meet all of the following;</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
	<p>1. Serum sodium concentration was normal within 1 week after starting Nocdurna and again at 1 month after starting Nocdurna, AND</p> <p>2. Patient has had a decrease in voiding episodes at night, AND</p> <p>3. Patient does not have an increased risk of severe hyponatremia, such as patients with a history of hyponatremia, excessive fluid intake, polydipsia, illnesses that can cause fluid or electrolyte imbalances (such as gastroenteritis, salt-wasting nephropathies, or systemic infection), renal impairment with estimated glomerular filtration rate (eGFR) below 50 mL/min/1.73 m², known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion, and in those using loop diuretics or systemic or inhaled glucocorticoids, AND</p> <p>4. Patient does not have heart failure, AND</p> <p>5. Patient does not have uncontrolled hypertension, AND</p> <p>6. Patient is not pregnant, AND</p> <p>7. Serum sodium concentration will be monitored periodically based on the patient's risk for hyponatremia but will be monitored more frequently for patients age 65 and older, and for patients on concomitant medications that can increase the risk of hyponatremia, such as tricyclic antidepressants, selective serotonin reuptake inhibitors, nonsteroidal anti-inflammatory drugs (NSAIDs), chlorpromazine, opiate analgesics, carbamazepine, lamotrigine, thiazide diuretics and chlorpropamide.</p>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month (initial authorization), 3 month (reauthorization)
Other Criteria	
QL Criteria	1 tablet Per 1 day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Notes/ References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Noctiva

Products Affected

- noctiva

QL Criteria	1 bottle Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nolix

Products Affected

- nolix external lotion

QL Criteria	4 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Norco

Products Affected

- norco oral tablet 10-325 mg

QL Criteria	9 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Norco

Products Affected

- norco oral tablet 5-325 mg, 7.5-325 mg

QL Criteria	12 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Norditropin FlexPro

Products Affected

- norditropin flexpro

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Northera

Products Affected

- northera oral capsule 100 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Northera

Products Affected

- northera oral capsule 200 mg, 300 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nova Max Glucose Test

Products Affected

- nova max glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Novarel

Products Affected

- *novarel intramuscular solution reconstituted*
10000 unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Novoeight

Products Affected

- novoeight

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

NovoSeven RT

Products Affected

- novoseven rt

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Noxafil

Products Affected

- noxafil oral tablet delayed release

QL Criteria	93 TBEC Per 30 DAYs
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucala

Products Affected

- nucala

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/RESP/Interleukin Antagonist.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 injection Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nucynta

Products Affected

- nucynta oral tablet 100 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Nucynta

Products Affected

- nucynta oral tablet 50 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Nucynta

Products Affected

- nucynta oral tablet 75 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Nucynta ER

Products Affected

- nucynta er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Nuedexta

Products Affected

- nuedexta

QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nuplazid

Products Affected

- nuplazid oral capsule

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Nuplazid.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nuplazid

Products Affected

- nuplazid oral tablet 10 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Nuplazid.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nuplazid

Products Affected

- nuplazid oral tablet 17 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Nuplazid.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nutropin AQ NuSpin 10

Products Affected

- nutropin aq nuspin 10

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nutropin AQ NuSpin 20

Products Affected

- nutropin aq nuspin 20

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nutropin AQ NuSpin 5

Products Affected

- nutropin aq nuspin 5

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nuvigil

Products Affected

- nuvigil

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping.
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nuwiq

Products Affected

- nuwiq

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Nymalize

Products Affected

- nymalize oral solution 60 mg/20ml

QL Criteria	135.2 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ocaliva

Products Affected

- ocaliva oral tablet 5 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Primary_Biliary_Cholangitis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Octagam

Products Affected

- octagam

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Octreotide Acetate

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Odefsey

Products Affected

- odefsey

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Odomzo

Products Affected

- odomzo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Odomzo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ofev

Products Affected

- ofev

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ofloxacin

Products Affected

- *ofloxacin oral tablet 300 mg*

QL Criteria	28 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OLANZapine

Products Affected

- *olanzapine oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg*
- *olanzapine oral tablet dispersible 15 mg, 20 mg, 5 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OLANZapine

Products Affected

- *olanzapine oral tablet 2.5 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OLANZapine

Products Affected

- *olanzapine oral tablet dispersible 10 mg*

QL Criteria	1 Tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl oral capsule 12-25 mg, 6-25 mg, 6-50 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl oral capsule 12-50 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Olmesartan Medoxomil

Products Affected

- *olmesartan medoxomil oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Olmesartan Medoxomil-HCTZ

Products Affected

- *olmesartan medoxomil-hctz*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Olmesartan-Amlodipine-HCTZ

Products Affected

- *olmesartan-amlodipine-hctz*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Olumiant

Products Affected

- olumiant

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Olumiant.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: June 27, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Olux

Products Affected

- olux

QL Criteria	100 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Olux-E

Products Affected

- olux-e

QL Criteria	100 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Omeprazole-Sodium Bicarbonate

Products Affected

- *omeprazole-sodium bicarbonate oral capsule*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Omeprazole-Sodium Bicarbonate

Products Affected

- *omeprazole-sodium bicarbonate oral packet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 pack Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Omnitrope

Products Affected

- omnitrope

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

On Call Express Blood Glucose

Products Affected

- on call express blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

On Call Plus Blood Glucose

Products Affected

- on call plus blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

On Call Vivid Blood Glucose

Products Affected

- on call vivid blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OneTouch Ultra Blue

Products Affected

- onetouch ultra blue

QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OneTouch Verio

Products Affected

- onetouch verio in vitro strip

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Onfi

Products Affected

- onfi oral tablet 10 mg, 20 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onglyza

Products Affected

- onglyza

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Onzetra Xsail

Products Affected

- onzetra xsail

QL Criteria	1 kit Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opana

Products Affected

- opana oral tablet 10 mg

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Opana

Products Affected

- opana oral tablet 5 mg

QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opsumit

Products Affected

- opsumit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OptumRx Blood Glucose Test

Products Affected

- optumrx blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oracea

Products Affected

- oracea

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oravig

Products Affected

- oravig

QL Criteria	14 tablets Per 1 fill
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orencia

Products Affected

- orencia intravenous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orencia

Products Affected

- orencia subcutaneous solution prefilled syringe 125 mg/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orencia

Products Affected

- orencia subcutaneous solution prefilled syringe 50 mg/0.4ml, 87.5 mg/0.7ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orencia ClickJect

Products Affected

- orencia clickject

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orenitram

Products Affected

- orenitram

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orfadin

Products Affected

- orfadin

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orilissa

Products Affected

- orilissa oral tablet 150 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tab/day Per 730 lifetime days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orilissa

Products Affected

- orilissa oral tablet 200 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tabs/day Per 180 lifetime days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orkambi

Products Affected

- orkambi oral packet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orkambi

Products Affected

- orkambi oral tablet 100-125 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Orkambi

Products Affected

- orkambi oral tablet 200-125 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OrthoVisc

Products Affected

- orthovisc intra-articular solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oseltamivir Phosphate

Products Affected

- *oseltamivir phosphate oral capsule*

QL Criteria	20 capsules Per 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oseltamivir Phosphate

Products Affected

- *oseltamivir phosphate oral suspension reconstituted*

QL Criteria	480 mls Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oseni

Products Affected

- oseni

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Osmolex ER

Products Affected

- osmolex er

PA Criteria	Criteria Details
Covered Uses	Treatment of symptoms of Parkinsons disease, treatment of drug-induced extrapyramidal reactions
Exclusion Criteria	Contraindicated in patients with end stage renal disease
Required Medical Information	Adults with a documented diagnosis of Parkinsons disease OR drug-induced extrapyramidal reactions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Parkinsons disease or drug-induced extrapyramidal reactions in adults AND There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: June 19, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Otezla

Products Affected

- otezla oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Otezla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Otezla

Products Affected

- otezla oral tablet therapy pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Otezla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ovidrel

Products Affected

- ovidrel

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/inferility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxaydo

Products Affected

- oxaydo oral tablet abuse-deterrent 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxaydo

Products Affected

- oxaydo oral tablet abuse-deterrent 7.5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxiconazole Nitrate

Products Affected

- *oxiconazole nitrate*

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxistat

Products Affected

- oxistat

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxtellar XR

Products Affected

- oxtellar xr oral tablet extended release 24 hour 150 mg, 300 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxtellar XR

Products Affected

- oxtellar xr oral tablet extended release 24 hour 600 mg

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxybutynin Chloride

Products Affected

- *oxybutynin chloride oral tablet*

QL Criteria	4 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er oral tablet extended release 24 hour 5 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 capsules Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral concentrate 100 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	60 MLS Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet 15 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet 20 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet 30 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OxyCODONE HCl ER

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OxyCODONE HCl ER

Products Affected

- oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxycodone-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral tablet 10-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxycodone-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxycodone-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral tablet 7.5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxycodone-Aspirin

Products Affected

- *oxycodone-aspirin oral tablet 4.8355-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxycodone-Ibuprofen

Products Affected

- *oxycodone-ibuprofen*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

OxyCONTIN

Products Affected

- oxycontin oral tablet er 12 hour abuse-deterrent

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxymorphone HCl

Products Affected

- *oxymorphone hcl oral tablet 10 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Oxymorphone HCl

Products Affected

- *oxymorphone hcl oral tablet 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

OxyMORphone HCl ER

Products Affected

- *oxymorphone hcl er*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Oxytrol For Women

Products Affected

- oxytrol for women

QL Criteria	8 patches Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ozempic

Products Affected

- ozempic subcutaneous solution pen-injector 0.25 or 0.5 mg/dose

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Not indicated for use in type 1 diabetes mellitus or treatment of diabetic ketoacidosis, if member has pancreatitis, in patients with a personal or family history of medullary thyroid carcinoma or in patients with multiple endocrine neoplasia syndrome, or for members with type 2 and known hypersensitivity to Ozempic or any of the product components.
Required Medical Information	Member must have a HbA1c greater than or equal to 6.5%, documentation of type 2 diabetes, and is requesting the medication in use as adjunctive to diet and exercise.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 pen Per 28 Days
Notes/References	
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: January 09, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ozempic

Products Affected

- ozempic subcutaneous solution pen-injector 1 mg/dose

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Not indicated for use in type 1 diabetes mellitus or treatment of diabetic ketoacidosis, if member has pancreatitis, in patients with a personal or family history of medullary thyroid carcinoma or in patients with multiple endocrine neoplasia syndrome, or for members with type 2 and known hypersensitivity to Ozempic or any of the product components.
Required Medical Information	Member must have a HbA1c greater than or equal to 6.5%, documentation of type 2 diabetes, and is requesting the medication in use as adjunctive to diet and exercise.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 pens Per 28 Days
Notes/References	
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: January 25, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release*
24 hour 1.5 mg, 3 mg, 6 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release*
24 hour 9 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Palynziq

Products Affected

- palynziq

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Panzyga

Products Affected

- panzyga

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Paricalcitol

Products Affected

- *paricalcitol oral*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 10 mg, 20 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 37.5 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hour 25 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PARoxetine Mesylate

Products Affected

- *paroxetine mesylate*

PA Criteria	Criteria Details
Covered Uses	Moderate to severe vasomotor symptoms associated with menopause
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 capsule Per 1 day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Paxil

Products Affected

- paxil oral suspension

QL Criteria	30 ml Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paxil

Products Affected

- paxil oral tablet 10 mg, 20 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Paxil

Products Affected

- paxil oral tablet 30 mg, 40 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paxil CR

Products Affected

- paxil cr

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pegasys

Products Affected

- pegasys subcutaneous solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Pegasys.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pegasys ProClick

Products Affected

- pegasys proclick

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Pegasys.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Penlac

Products Affected

- penlac

PA Criteria	Criteria Details
Covered Uses	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Failure of an adequate trial of one systemic oral alternative is terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail), OR If member has hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or is female and is pregnant and/or breastfeeding. (No trial needed)
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pennsaid

Products Affected

- pennsaid transdermal solution 2 %

QL Criteria	4 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pentasa

Products Affected

- pentasa oral capsule extended release 250 mg

QL Criteria	16 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- pentasa oral capsule extended release 500 mg

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pentazocine-Naloxone HCl

Products Affected

- *pentazocine-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	5 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Percocet

Products Affected

- percocet oral tablet 10-325 mg

QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Percocet

Products Affected

- percocet oral tablet 2.5-325 mg, 5-325 mg

QL Criteria	12 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Percocet

Products Affected

- percocet oral tablet 7.5-325 mg

QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Perforomist

Products Affected

- perforomist

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	Documented physical limitation that prevents the use of a non-nebulized long-acting bronchodilator with or without use of a spacer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	4 milliliters Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pexeva

Products Affected

- pexeva oral tablet 10 mg, 20 mg, 40 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pexeva

Products Affected

- pexeva oral tablet 30 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Phenoxybenzamine HCl

Products Affected

- *phenoxybenzamine hcl oral*

QL Criteria	12 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Phytonadione

Products Affected

- *phytonadione oral*

QL Criteria	25 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Picato

Products Affected

- picato external gel 0.015 %

QL Criteria	3 unit dose tubes Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Picato

Products Affected

- picato external gel 0.05 %

QL Criteria	2 unit dose tubes Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pioglitazone HCl

Products Affected

- *pioglitazone hcl*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pioglitazone HCl-Glimepiride

Products Affected

- *pioglitazone hcl-glimepiride*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-metformin hcl*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Plavix

Products Affected

- plavix

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Plegridy

Products Affected

- plegridy

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Plegridy Starter Pack

Products Affected

- plegridy starter pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Plixda

Products Affected

- plixda

QL Criteria	1 pad Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: October 22, 2018

PocketChem EZ Test

Products Affected

- pocketchem ez test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pomalyst

Products Affected

- pomalyst

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ponstel

Products Affected

- ponstel

QL Criteria	30 capsules Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Potassium Chloride

Products Affected

- *potassium chloride oral packet*

QL Criteria	5 packs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pradaxa

Products Affected

- pradaxa

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Praluent

Products Affected

- praluent subcutaneous solution pen-injector

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCS_K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er oral tablet*
extended release 24 hour 0.375 mg, 2.25
mg, 3 mg, 3.75 mg, 4.5 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er oral tablet*
extended release 24 hour 0.75 mg, 1.5 mg

QL Criteria	1 TAB Per 1 DAILY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prasugrel HCl

Products Affected

- *prasugrel hcl*

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS) managed with percutaneous coronary intervention which includes unstable angina or non-ST elevation myocardial infarction or ST elevation myocardial infarction (MI)
Exclusion Criteria	History of Stroke or transient ischemic attack (TIA)
Required Medical Information	Member has a documented diagnosis of acute coronary syndrome (ACS) and is managed by percutaneous coronary intervention (PCI), which includes unstable angina, non-ST-elevation myocardial infarction (NSTEMI), or ST -elevation myocardial infarction (STEMI) managed with primary or delayed PCI and member has no prior history of stroke or transient ischemic attack (TIA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 22, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pravachol

Products Affected

- pravachol oral tablet 20 mg, 40 mg, 80 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Precision PCx

Products Affected

- precision pcx

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Precision PCX Plus Test

Products Affected

- precision pcx plus test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Precision Point of Care Test

Products Affected

- precision point of care test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Precision QID Test

Products Affected

- precision qid test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Precision Sof-Tact Test

Products Affected

- precision sof-tact test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Precision Xtra Blood Glucose

Products Affected

- precision xtra blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prefest

Products Affected

- prefest

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pregnyl

Products Affected

- *pregnyl*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prevacid

Products Affected

- prevacid oral capsule delayed release 30 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prevacid 24HR

Products Affected

- prevacid 24hr

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prevacid SoluTab

Products Affected

- prevacid solutab

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prevymis

Products Affected

- prevymis oral

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/Prevymis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prezista

Products Affected

- prezista oral suspension

QL Criteria	2 bottles Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prezista

Products Affected

- prezista oral tablet 150 mg, 600 mg, 75 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prezista

Products Affected

- prezista oral tablet 800 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PriLOSEC

Products Affected

- prilosec oral packet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Primlev

Products Affected

- primlev oral tablet 10-300 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Primlev

Products Affected

- primlev oral tablet 5-300 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Primlev

Products Affected

- primlev oral tablet 7.5-300 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Pristiq

Products Affected

- pristiq oral tablet extended release 24 hour
100 mg, 50 mg

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pristiq

Products Affected

- pristiq oral tablet extended release 24 hour
25 mg

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Privigen

Products Affected

- privigen

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Procardia XL

Products Affected

- procardia xl oral tablet extended release 24 hour 30 mg, 90 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Procardia XL

Products Affected

- procardia xl oral tablet extended release 24 hour 60 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ProCentra

Products Affected

- procentra

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) OR Narcolepsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD OR Narcolepsy AND there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	40 MLS Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Procrit

Products Affected

- procrit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2018/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Proctofoam HC

Products Affected

- proctofoam hc

QL Criteria	20 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Procysbi

Products Affected

- procysbi oral capsule delayed release 25 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Procysbi

Products Affected

- procysbi oral capsule delayed release 75 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	25 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prodigy No Coding Blood Gluc

Products Affected

- prodigy no coding blood gluc

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Profilnine

Products Affected

- profilnine

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Profilnine SD

Products Affected

- profilnine sd

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Progesterone Micronized

Products Affected

- *progesterone micronized oral*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prolastin-C

Products Affected

- prolastin-c intravenous solution reconstituted 1000 mg
- prolastin-c intravenous solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Alp ha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prolia

Products Affected

- prolia

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Promacta

Products Affected

- promacta oral tablet 12.5 mg, 25 mg, 50 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Promacta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Promacta

Products Affected

- promacta oral tablet 75 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Promacta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prometrium

Products Affected

- prometrium

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Propafenone HCl ER

Products Affected

- *propafenone hcl er*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Proscar

Products Affected

- proscar

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of BPH (Benign Prostatic Hyperplasia). For female members, must have a documented diagnosis of hirsutism secondary to ovarian or adrenal dysfunction (for example, polycystic ovary syndrome, adrenal or ovarian tumor)and must not be pregnant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Protopic

Products Affected

- protopic

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis, Vitiligo
Exclusion Criteria	
Required Medical Information	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patients condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. FOR PROTOPIC 0.03%: A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required) or a documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or child 2 years of age or older and either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patients condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Provigil

Products Affected

- provigil oral tablet 100 mg

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with modafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Provigil

Products Affected

- provigil oral tablet 200 mg

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with modafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PROzac

Products Affected

- prozac oral capsule 10 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PROzac

Products Affected

- prozac oral capsule 20 mg

QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PROzac

Products Affected

- prozac oral capsule 40 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Prudoxin

Products Affected

- prudoxin

QL Criteria	45 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PTS Panels Glucose Test

Products Affected

- pts panels glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pulmicort

Products Affected

- pulmicort

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	For ages 5-8 documented inability to use metered dose inhalers, No prior authorization required for children 1-4 years of age. Medical Exception allowed for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory and for Nasal Polyps when all criteria met: A diagnosis of chronic sinusitis with nasal polyposis, endoscopic sinus surgery has been performed, and standard nasal steroid sprays have been used as part of post-operative management and have failed.
Age Restrictions	Less than 8 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	4 MLS Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pulmicort Flexhaler

Products Affected

- pulmicort flexhaler

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Pulmozyme

Products Affected

- pulmozyme

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ampules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Purixan

Products Affected

- purixan

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3.5 ML Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Qbrelis

Products Affected

- qbrelis

PA Criteria	Criteria Details
Covered Uses	Hypertension, Heart Failure, Myocardial Infarction
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension (Approved only for ages 6 and older), Heart failure, or Myocardial Infarction AND must have a documented inability to swallow tablets/capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Qbrexza

Products Affected

- qbrexza

PA Criteria	Criteria Details
Covered Uses	For topical treatment of primary axillary hyperhidrosis in adult and pediatric patients greater than 9 years old
Exclusion Criteria	Medical conditions that can be exacerbated by the anticholinergic effect of glycopyrronium (eg, glaucoma, paralytic ileus, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis, Sjogren syndrome).
Required Medical Information	A documented diagnosis of primary axillary hyperhidrosis in adult and pediatric patients greater than 9 years old. Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of symptom improvement from baseline.
Age Restrictions	Greater than 9 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 pad Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Qtern

Products Affected

- qtern

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: December 12, 2017

Qudexy XR

Products Affected

- qudexy xr oral capsule er 24 hour sprinkle
100 mg, 25 mg, 50 mg

QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Qudexy XR

Products Affected

- qudexy xr oral capsule er 24 hour sprinkle
150 mg, 200 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 100 mg, 50 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 300 mg, 400 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 300 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 400 mg, 50 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

QuickTek Test

Products Affected

- quicktek test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QuilliChew ER

Products Affected

- quillichew er oral tablet chewable
extended release 20 mg, 40 mg

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

QuilliChew ER

Products Affected

- quillichew er oral tablet chewable
extended release 30 mg

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Quillivant XR

Products Affected

- quillivant xr

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	12 milliliters Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Quintet AC Blood Glucose Test

Products Affected

- quintet ac blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Quintet Blood Glucose Test

Products Affected

- quintet blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Qvar RediHaler

Products Affected

- qvar redihaler

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RA Nicotine

Products Affected

- *ra nicotine transdermal*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RA TRUEtest Test

Products Affected

- ra truetest test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ranexa

Products Affected

- ranexa

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rasagiline Mesylate

Products Affected

- *rasagiline mesylate oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ravicti

Products Affected

- ravicti

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	20 bottles Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rayaldee

Products Affected

- rayaldee

PA Criteria	Criteria Details
Covered Uses	Treatment of secondary hyperparathyroidism in adult patients with stage 3 or 4 chronic kidney disease (CKD)
Exclusion Criteria	Patients with stage 5 CKD or in patients with end stage renal disease (ESRD) on dialysis
Required Medical Information	A documented diagnosis of secondary hyperparathyroidism and Stage 3 or 4 chronic kidney disease (CKD) and serum total 25-hydroxyvitamin D level is less than 30 ng/mL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsules Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: December 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Razadyne

Products Affected

- razadyne oral tablet

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Razadyne ER

Products Affected

- razadyne er

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rebetol

Products Affected

- rebetol oral solution

QL Criteria	5 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebif

Products Affected

- rebif subcutaneous solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rebif Rebidose

Products Affected

- rebif rebidose subcutaneous solution auto-injector

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rebif Rebidose Titration Pack

Products Affected

- rebif rebidose titration pack subcutaneous solution auto-injector

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rebif Titration Pack

Products Affected

- rebif titration pack subcutaneous solution
prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rebinyn

Products Affected

- rebinyn

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Recombinate

Products Affected

- recombinate

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rectiv

Products Affected

- rectiv

QL Criteria	1 tube Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RefuAH Plus Blood Glucose Test

Products Affected

- refuah plus blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Regranex

Products Affected

- regranex

PA Criteria	Criteria Details
Covered Uses	Treatment of lower extremity diabetic neuropathic ulcers
Exclusion Criteria	Documentation that the patient has NONE of the following: Neoplasm(s) at the sites(s) of application, will not be using in pressure ulcers, venous stasis ulcers, or ischemic diabetic ulcers, exposed joints, tendons, ligaments, and bone (at application site), or will not be using in wounds that close by primary intention (such as suturing or gluing)
Required Medical Information	A documented diagnosis of diabetes with lower extremity neuropathic ulcers that extend into the subcutaneous tissue or beyond with adequate blood supply
Age Restrictions	16 years or older
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	NOTE: The safety and efficacy of treatment beyond 20 weeks have not been determined.
QL Criteria	30 grams Per 30 Days
Notes/References	
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: November 09, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Relenza Diskhaler

Products Affected

- relenza diskhaler

QL Criteria	40 disks Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Relexxii

Products Affected

- relexxii

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Relistor

Products Affected

- relistor oral

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain and documented concomitant use of opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Relistor

Products Affected

- relistor subcutaneous solution 12 mg/0.6ml

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.6 ML Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Relistor

Products Affected

- relistor subcutaneous solution 8 mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.4 ML Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Relpax

Products Affected

- relpax

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Remeron

Products Affected

- remeron oral tablet 15 mg, 30 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remeron SolTab

Products Affected

- remeron soltab

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Remicade

Products Affected

- remicade

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Remicade.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Remodulin

Products Affected

- remodulin

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Renflexis

Products Affected

- renflexis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Renflexis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Repaglinide-Metformin HCl

Products Affected

- *repaglinide-metformin hcl*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Repatha

Products Affected

- repatha

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCS_K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 units Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Repatha Pushtronex System

Products Affected

- repatha pushtronex system

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCS_K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 30 days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Repatha SureClick

Products Affected

- repatha sureclick

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 units Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Requip XL

Products Affected

- requip xl oral tablet extended release 24 hour 12 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Requip XL

Products Affected

- requip xl oral tablet extended release 24 hour 2 mg, 4 mg, 6 mg, 8 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Restoril

Products Affected

- restoril oral capsule 22.5 mg, 7.5 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Retacrit

Products Affected

- retacrit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2018/MISC/Erythroipoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Retin-A

Products Affected

- retin-a

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Retin-A Micro

Products Affected

- retin-a micro

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Retin-A Micro Pump

Products Affected

- retin-a micro pump

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revatio

Products Affected

- revatio intravenous
- revatio oral suspension reconstituted

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Revatio

Products Affected

- revatio oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Reveal Blood Glucose Test

Products Affected

- reveal blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Revlimid

Products Affected

- revlimid

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rexulti

Products Affected

- rexulti

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD), Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder (MDD) or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Major Depressive Disorder (MDD) or Schizophrenia AND A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Reyataz

Products Affected

- reyataz oral capsule 150 mg, 300 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Reyataz

Products Affected

- reyataz oral capsule 200 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rhofade

Products Affected

- rhofade

QL Criteria	4 tubes Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RiaSTAP

Products Affected

- riastap

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Riastap.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rightest GS100 Blood Glucose

Products Affected

- rightest gs100 blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rightest GS300 Blood Glucose

Products Affected

- rightest gs300 blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rightest GS550 Blood Glucose

Products Affected

- rightest gs550 blood glucose

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rilutek

Products Affected

- rilutek

PA Criteria	Criteria Details
Covered Uses	Amyotrophic Lateral Sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Riluzole

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	Amyotrophic Lateral Sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

QL Criteria	1 tablet Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 30 mg, 5 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 35 mg* *release*
- *risedronate sodium oral tablet delayed*

QL Criteria	4 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- risperdal oral solution

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Autistic Disorder, Bipolar Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder AND There is clinical documentation indicating disease stability or improvement from baseline
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RisperDAL

Products Affected

- risperdal oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Autistic Disorder, Bipolar Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RisperDAL

Products Affected

- risperdal oral tablet 4 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Autistic Disorder, Bipolar Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RisperiDONE

Products Affected

- *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral tablet 3 mg*
- *risperidone oral tablet dispersible 3 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RisperiDONE

Products Affected

- *risperidone oral tablet 4 mg*
- *risperidone oral tablet dispersible 4 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperidONE M-TAB

Products Affected

- risperidone m-tab oral tablet dispersible
0.5 mg, 1 mg, 2 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ritalin

Products Affected

- ritalin

QL Criteria	6 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ritalin LA

Products Affected

- ritalin la oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ritalin LA

Products Affected

- ritalin la oral capsule extended release 24 hour 30 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rituxan

Products Affected

- rituxan intravenous solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Rituxan.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rivastigmine

Products Affected

- *rivastigmine*

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rivastigmine Tartrate

Products Affected

- *rivastigmine tartrate*

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rixubis

Products Affected

- rixubis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

QL Criteria	12 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release*
24 hour 12 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release*
24 hour 2 mg, 4 mg, 6 mg, 8 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Roxicodone

Products Affected

- roxicodone oral tablet 15 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Roxicodone

Products Affected

- roxicodone oral tablet 30 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Roxicodone

Products Affected

- roxicodone oral tablet 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

RoxyBond

Products Affected

- roxybond oral tablet abuse-deterrent 15 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	4 tablets Per 1 day over 7 days
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

RoxyBond

Products Affected

- roxybond oral tablet abuse-deterrent 30 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 day over 7 days
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: October 22, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

RoxyBond

Products Affected

- roxybond oral tablet abuse-deterrent 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	6 tablets Per 1 day over 7 days
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rozerem

Products Affected

- rozerem

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 08/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rubraca

Products Affected

- rubraca oral tablet 200 mg, 300 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOP/L/Rubraca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rubraca

Products Affected

- rubraca oral tablet 250 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Rubraca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ruconest

Products Affected

- ruconest

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rydapt

Products Affected

- rydapt

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Rydapt.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Rythmol SR

Products Affected

- rythmol sr

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RyVent

Products Affected

- ryvent

PA Criteria	Criteria Details
Covered Uses	Seasonal and perennial allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods, mild uncomplicated allergic skin manifestations of urticaria and angioedema, dermatographism, as therapy for anaphylactic reactions adjunctive to epinephrine, amelioration of the severity of allergic reactions to blood or plasma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seasonal and perennial allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods, mild uncomplicated allergic skin manifestations of urticaria and angioedema, dermatographism, as therapy for anaphylactic reactions adjunctive to epinephrine, or amelioration of the severity of allergic reactions to blood or plasma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating stability or improvement in symptoms from baseline.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Sabril

Products Affected

- sabril oral packet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sabril

Products Affected

- sabril oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Saizen

Products Affected

- saizen

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Samsca

Products Affected

- samsca oral tablet 15 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Samsca

Products Affected

- samsca oral tablet 30 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sancuso

Products Affected

- sancuso

QL Criteria	1 patch Per 1 month
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SandoSTATIN

Products Affected

- sandostatin injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SandoSTATIN LAR Depot

Products Affected

- sandostatin lar depot

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Santyl

Products Affected

- santyl

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saphris

Products Affected

- saphris sublingual tablet sublingual 10 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	Bipolar disorder, Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Bipolar Disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Bipolar Disorder or Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Saphris

Products Affected

- saphris sublingual tablet sublingual 2.5 mg

PA Criteria	Criteria Details
Covered Uses	Bipolar disorder, Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Bipolar Disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Bipolar Disorder or Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Savaysa

Products Affected

- savaysa

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Savella

Products Affected

- savella

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella Titration Pack

Products Affected

- savella titration pack

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Seebri Neohaler

Products Affected

- seebri neohaler

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Segluromet

Products Affected

- segluromet oral tablet 2.5-1000 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 14, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Segluromet

Products Affected

- segluromet oral tablet 2.5-500 mg

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 26, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Segluromet

Products Affected

- segluromet oral tablet 7.5-1000 mg, 7.5-500 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Selzentry

Products Affected

- selzentry oral solution

QL Criteria	8 bottles Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Selzentry

Products Affected

- selzentry oral tablet 150 mg, 75 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Selzentry

Products Affected

- selzentry oral tablet 25 mg

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sensipar

Products Affected

- sensipar

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Serevent Diskus

Products Affected

- serevent diskus

QL Criteria	2 blisters Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SEROquel

Products Affected

- seroquel oral tablet 100 mg, 50 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SEROquel

Products Affected

- seroquel oral tablet 200 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SEROquel

Products Affected

- seroquel oral tablet 25 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	6 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SEROquel

Products Affected

- seroquel oral tablet 300 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SEROquel XR

Products Affected

- seroquel xr oral tablet extended release 24 hour 150 mg, 200 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SEROquel XR

Products Affected

- seroquel xr oral tablet extended release 24 hour 300 mg, 400 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- seroquel xr oral tablet extended release 24 hour 50 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Serostim

Products Affected

- serostim subcutaneous solution
reconstituted 4 mg, 5 mg, 6 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Signifor

Products Affected

- signifor

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 SOLN Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Signifor LAR

Products Affected

- signifor lar intramuscular suspension reconstituted er

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 vial Per 28 days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Siklos

Products Affected

- siklos

PA Criteria	Criteria Details
Covered Uses	Sickle cell anemia with recurrent moderate to severe painful crises
Exclusion Criteria	
Required Medical Information	For ages 19 years or greater, the following criteria must be met: A documented diagnosis of sickle cell anemia with recurrent moderate to severe painful crises and a documented contraindication, intolerance, allergy, or failure of Droxia
Age Restrictions	Less than 2 or greater than 18 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	No prior authorization required for children 2-18 years of age. Continuation Criteria There is clinical documentation indicating disease stability or improvement for baseline.
Notes/References	
Revision Date	Prior Authorization: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sildenafil Citrate

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Silenor

Products Affected

- silenor

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Siliq

Products Affected

- siliq

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Siliq.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Simponi

Products Affected

- simponi subcutaneous solution auto-injector
- simponi subcutaneous solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Simponi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Simponi Aria

Products Affected

- simponi aria

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Simponi_Aria.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Simvastatin

Products Affected

- *simvastatin oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Singulair

Products Affected

- singulair oral packet

QL Criteria	1 pack Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Singulair

Products Affected

- singulair oral tablet
- singulair oral tablet chewable

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sirturo

Products Affected

- sirturo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antimycobacterial_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	188 EA Per 365 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sivextro

Products Affected

- sivextro oral

QL Criteria	6 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SM Nicotine

Products Affected

- *sm nicotine transdermal*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Smart Sense Value Test

Products Affected

- smart sense value test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Smartest Blood Glucose Test

Products Affected

- smartest blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate oral powder 3 gmltsp*
- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Solia

Products Affected

- *solia*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Soliqua

Products Affected

- soliqua

QL Criteria	5 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Solosec

Products Affected

- solosec

QL Criteria	1 packet Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Solus V2 Test

Products Affected

- solus v2 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Somatuline Depot

Products Affected

- somatuline depot

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/San_dostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Somavert

Products Affected

- somavert

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Soriatane

Products Affected

- soriatane oral capsule 10 mg, 25 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sorilux

Products Affected

- sorilux

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sovaldi

Products Affected

- sovaldi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Sovaldi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Spiriva HandiHaler

Products Affected

- spiriva handihaler

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Spiriva Respimat

Products Affected

- spiriva respimat inhalation aerosol solution 1.25 mcg/act

QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Spiriva Respimat

Products Affected

- spiriva respimat inhalation aerosol solution 2.5 mcg/act

QL Criteria	1 inhaler Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sporanox

Products Affected

- sporanox oral capsule

QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sporanox Pulsepak

Products Affected

- sporanox pulsepak

QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Spritam

Products Affected

- spritam

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sprix

Products Affected

- sprix

QL Criteria	5 days maximum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sprycel

Products Affected

- sprycel oral tablet 100 mg, 140 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sprycel

Products Affected

- sprycel oral tablet 20 mg, 50 mg, 70 mg, 80 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Steglatro

Products Affected

- steglatro oral tablet 15 mg

QL Criteria	1 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 13, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Steglatro

Products Affected

- steglatro oral tablet 5 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Steglujan

Products Affected

- steglujan

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Stelara

Products Affected

- stelara intravenous

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Stelara

Products Affected

- stelara subcutaneous solution 45 mg/0.5ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 injection Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Stelara

Products Affected

- stelara subcutaneous solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Stimate

Products Affected

- stimate

PA Criteria	Criteria Details
Covered Uses	Hemophilia A, von Willebrand's disease Type 1
Exclusion Criteria	
Required Medical Information	A documented diagnosis of von Willebrand's disease Type 1 (and aged at least 11 months) or a diagnosis of Hemophilia A without the presence of Factor VIII antibodies and documentation of greater than 5% Factor VIII coagulant activity
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: January 26, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Stiolto Respimat

Products Affected

- stiolto respimat inhalation aerosol solution 2.5-2.5 mcg/act

QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stivarga

Products Affected

- stivarga

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Strattera

Products Affected

- strattera oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strattera

Products Affected

- strattera oral capsule 100 mg, 80 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Strensiq

Products Affected

- strensiq

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Striant

Products Affected

- striant

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	2 buccals Per 1 Day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Stribild

Products Affected

- stribild

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Striverdi Respimat

Products Affected

- striverdi respimat

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Suboxone

Products Affected

- suboxone sublingual film 12-3 mg

QL Criteria	2 films Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Suboxone

Products Affected

- suboxone sublingual film 2-0.5 mg, 4-1 mg

QL Criteria	3 films Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- suboxone sublingual film 8-2 mg

QL Criteria	3 films Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Subsys

Products Affected

- subsys

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
QL Criteria	120 sprays Per 30 Days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Sular

Products Affected

- sular oral tablet extended release 24 hour
17 mg, 34 mg, 8.5 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SulfaSALazine

Products Affected

- *sulfasalazine oral*

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sulfazine

Products Affected

- *sulfazine*

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan

Products Affected

- *sumatriptan nasal*

QL Criteria	6 sprays Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SUMatriptan Succinate

Products Affected

- *sumatriptan succinate oral*

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMatriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution 6 mg/0.5ml*

QL Criteria	10 vials/30 days Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SUMatriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml*

QL Criteria	10 cart/30 day Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMatriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill subcutaneous solution cartridge*

QL Criteria	10 cart/30 day Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sumatriptan-Naproxen Sodium

Products Affected

- *sumatriptan-naproxen sodium*

QL Criteria	10 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 16, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Supartz FX

Products Affected

- supartz fx

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Supprelin LA

Products Affected

- supprelin la

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Supreme Test

Products Affected

- supreme test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sure Edge Test

Products Affected

- sure edge test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SureChek Blood Glucose Test

Products Affected

- surechek blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sure-Test EasyPlus Mini Test

Products Affected

- sure-test easyplus mini test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected

- sutent oral capsule 12.5 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sutent

Products Affected

- sutent oral capsule 25 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sutent

Products Affected

- sutent oral capsule 37.5 mg, 50 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Sylatron

Products Affected

- sylatron subcutaneous kit 200 mcg, 300 mcg, 600 mcg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Symbicort

Products Affected

- symbicort

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Symbyax

Products Affected

- symbyax oral capsule 12-25 mg, 12-50 mg, 6-25 mg, 6-50 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Symdeko

Products Affected

- symdeko

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SymlinPen 120

Products Affected

- symlinpen 120 subcutaneous solution pen-injector

PA Criteria	Criteria Details
Covered Uses	All FDA Approved uses
Exclusion Criteria	Poor compliance with current insulin regimen, Poor compliance with prescribed self-blood glucose monitorings, An A1C greater than 9%, Recurrent severe hypoglycemia requiring assistance during the previous 6 months, Presence of hypoglycemia unawareness, Confirmed diagnosis of gastroparesis, Need for medications that stimulate GI motility , Patient is less than 18 years old, Concurrent use with other oral antidiabetic medications (except metformin and sulfonylureas) or drugs that alter gastrointestinal motility
Required Medical Information	A documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin). For extended renewals: a documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin), and the patient demonstrated an expected reduction in HbA1c since starting this therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	initial: 6 months - extended: 12 months
Other Criteria	
QL Criteria	4 pens Per 1 month
Notes/References	Annual Review: 05/2017

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

SymlinPen 60

Products Affected

- symmlinpen 60 subcutaneous solution pen-injector

PA Criteria	Criteria Details
Covered Uses	All FDA Approved uses
Exclusion Criteria	Poor compliance with current insulin regimen, Poor compliance with prescribed self-blood glucose monitorings, An A1C greater than 9%, Recurrent severe hypoglycemia requiring assistance during the previous 6 months, Presence of hypoglycemia unawareness, Confirmed diagnosis of gastroparesis, Need for medications that stimulate GI motility , Patient is less than 18 years old, Concurrent use with other oral antidiabetic medications (except metformin and sulfonylureas) or drugs that alter gastrointestinal motility
Required Medical Information	A documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin). For extended renewals: a documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin), and the patient demonstrated an expected reduction in HbA1c since starting this therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	initial: 6 months - extended: 12 months
Other Criteria	
Notes/References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Symproic

Products Affected

- symproic

PA Criteria	Criteria Details
Covered Uses	Treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain
Exclusion Criteria	Patients with known or suspected gastrointestinal obstruction or at increased risk of recurrent obstruction or with a history of a hypersensitivity reaction to naldemedine
Required Medical Information	A documented diagnosis of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain and the patient has been taking opioids for 4 weeks or more
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Symtuza

Products Affected

- symtuza

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synagis

Products Affected

- synagis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Synagis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synarel

Products Affected

- synarel

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Syndros

Products Affected

- syndros

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	4 bottles Per 1 month
Notes/References	
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synera

Products Affected

- synera

QL Criteria	10 patches Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synjardy

Products Affected

- synjardy

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synjardy XR

Products Affected

- synjardy xr oral tablet extended release 24 hour 10-1000 mg, 12.5-1000 mg, 5-1000 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synjardy XR

Products Affected

- synjardy xr oral tablet extended release 24 hour 25-1000 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synribo

Products Affected

- synribo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synvisc

Products Affected

- synvisc intra-articular solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Synvisc One

Products Affected

- synvisc one intra-articular solution
prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Syprine

Products Affected

- syprine

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Taclonex

Products Affected

- taclonex external suspension

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tacrolimus

Products Affected

- *tacrolimus external*

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis, Vitiligo
Exclusion Criteria	
Required Medical Information	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patients condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. FOR PROTOPIC 0.03%: A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required) or a documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or child 2 years of age or older and either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patients condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tadalafil

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	Erectile dysfunction coverage is not covered unless Contract state of NY (see other criteria below) or members with ED rider benefit
Required Medical Information	A documented diagnosis of BPH (Benign Prostatic Hyperplasia), member is not currently on nitrite/nitrate therapy, is not currently on another phosphodiesterase-5 inhibitor, and has a documented contraindication, intolerance, allergy, or failure of a one month trial of one of the preferred drugs alfuzosin, finasteride, tamsulosin, Avodart, Jalyn or Rapaflo
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (daily dosing covered only for BPH diagnosis)
Other Criteria	For Fully Insured members of contract state New York: A documented primary diagnosis of erectile dysfunction in adult males over 18 years of age and a documented secondary diagnosis of one of the following: Diabetes, Hypertension, Spinal cord injury, Multiple sclerosis, Stroke, Radical surgery of genital tract, urinary tract, or rectum, or Hypogonadism, and member is not receiving any of the following organic nitrate product: Isosorbide mononitrate (Ismo), isosorbide dinitrate (Sorbitrate, Isordil, Dilatrate-SR), Nitroglycerin (NTG, Nitrostat, Nitro-Dur, Transderm-Nitro, Minitran, Nitro-par, Nitrol, Nitro-Bid, others) and member is not currently on another phosphodiesterase-5 inhibitor indicated for erectile dysfunction, and there is a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred alternative Cialis (For request of Levitra, Staxyn, Stendra, and Viagra)

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Notes/ References	
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tadalafil (PAH)

Products Affected

- *tadalafil (pah)*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tafinlar

Products Affected

- tafinlar

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tagrisso

Products Affected

- tagrisso

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Tagrisso.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Take Action

Products Affected

- *take action*

QL Criteria	1 tablet Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Takhzyro

Products Affected

- takhzyro

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 vials Per 28 days
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Taltz

Products Affected

- taltz

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Taltz.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Talzenna

Products Affected

- talzenna oral capsule 0.25 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/talzenna.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Talzenna

Products Affected

- talzenna oral capsule 1 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/talzenna.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tamiflu

Products Affected

- tamiflu oral capsule

QL Criteria	20 capsules Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tamiflu

Products Affected

- tamiflu oral suspension reconstituted 6 mg/ml

QL Criteria	480 mls Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TaperDex 12-Day

Products Affected

- taperdex 12-day

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented inability to use single tablets or reach appropriate dosing regimen with using single tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: October 04, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TaperDex 6-Day

Products Affected

- taperdex 6-day

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented inability to use single tablets or reach appropriate dosing regimen with using single tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: October 04, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tarceva

Products Affected

- tarceva

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Targretin

Products Affected

- targretin

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Targretin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tasigna

Products Affected

- tasigna oral capsule 150 mg, 200 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tasigna

Products Affected

- tasigna oral capsule 50 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tavalisse

Products Affected

- tavalisse

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Tavalisse.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tazarotene

Products Affected

- *tazarotene external*

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris, plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris or plaque psoriasis
Age Restrictions	Prior authorization only required in patients older than 35 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: April 04, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tazorac

Products Affected

- tazorac

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris, plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris or plaque psoriasis
Age Restrictions	Prior authorization only required in patients older than 35 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: April 04, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Taztia XT

Products Affected

- *taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taztia XT

Products Affected

- *taztia xt oral capsule extended release 24 hour 240 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tecfidera

Products Affected

- tecfidera

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Tecfidera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Technivie

Products Affected

- technivie

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Technivie.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tekturna

Products Affected

- tekturna

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tekturna HCT

Products Affected

- tekturna hct

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Telcare Blood Glucose Test

Products Affected

- telcare blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Telmisartan

Products Affected

- *telmisartan*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Telmisartan-Amlodipine

Products Affected

- *telmisartan-amlodipine*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Telmisartan-HCTZ

Products Affected

- *telmisartan-hctz*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Temazepam

Products Affected

- *temazepam oral capsule 22.5 mg, 7.5 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Temodar

Products Affected

- temodar oral

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Temovate

Products Affected

- temovate external cream
- temovate external ointment

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Temozolomide

Products Affected

- *temozolomide*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tenofovir Disoproxil Fumarate

Products Affected

- *tenofovir disoproxil fumarate*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testim

Products Affected

- testim

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	10 grams Per 1 Day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Testosterone

Products Affected

- *testosterone transdermal gel 10 mg/lact (2%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	4 grams Per 1 Day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Testosterone

Products Affected

- *testosterone transdermal gel 12.5 mg/lact (1%), 50 mg/5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	10 grams Per 1 Day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Testosterone

Products Affected

- *testosterone transdermal gel 20.25 mg/1.25gm (1.62%), 20.25 mg/lact (1.62%), 40.5 mg/2.5gm (1.62%)*

QL Criteria	5 grams Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Testosterone

Products Affected

- *testosterone transdermal gel 25 mg/2.5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	2.5 grams Per 1 Day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Testosterone

Products Affected

- *testosterone transdermal solution*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	6 ml Per 1 day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tetrabenazine

Products Affected

- tetrabenazine oral tablet 12.5 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tetrabenazine

Products Affected

- tetrabenazine oral tablet 25 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TGT Nicotine Step One

Products Affected

- *tgt nicotine step one*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TGT Nicotine Step Three

Products Affected

- *tgt nicotine step three*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TGT Nicotine Step Two

Products Affected

- *tgt nicotine step two*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thalomid

Products Affected

- thalomid

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Thiola

Products Affected

- thiola

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Thrive

Products Affected

- *thrive mouth/throat gum 2 mg*

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 12 mg, 4 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 16 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 2 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tiazac

Products Affected

- tiazac oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg, 420 mg

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tiazac

Products Affected

- tiazac oral capsule extended release 24 hour 240 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tibsovo

Products Affected

- tibsovo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Tibsovo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 17, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tiglutik

Products Affected

- tiglutik

PA Criteria	Criteria Details
Covered Uses	Amyotrophic Lateral Sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 ml Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tivicay

Products Affected

- tivicay oral tablet 10 mg, 25 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tivicay

Products Affected

- tivicay oral tablet 50 mg

QL Criteria	2 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tivorbex

Products Affected

- tivorbex

PA Criteria	Criteria Details
Covered Uses	Management of mild to moderate acute pain in patients 18 years of age and older.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild to moderate acute pain
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	3 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tobi

Products Affected

- tobi

QL Criteria	10 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tobi Podhaler

Products Affected

- tobi podhaler

QL Criteria	1 CAPS Per 28 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tobramycin

Products Affected

- *tobramycin inhalation*

QL Criteria	10 ml Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Topamax Sprinkle

Products Affected

- topamax sprinkle

QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Topicort Spray

Products Affected

- topicort spray

QL Criteria	100 MLS Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Topiramate

Products Affected

- *topiramate oral capsule sprinkle*

QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toprol XL

Products Affected

- toprol xl oral tablet extended release 24 hour 100 mg, 50 mg

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Toprol XL

Products Affected

- toprol xl oral tablet extended release 24 hour 200 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toprol XL

Products Affected

- toprol xl oral tablet extended release 24 hour 25 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Toviaz

Products Affected

- toviaz

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tracleer

Products Affected

- tracleer

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tradjenta

Products Affected

- tradjenta

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TraMADol HCl

Products Affected

- *tramadol hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral capsule extended release 24 hour*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral tablet extended release*
24 hour

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.</p>
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TraMADol HCl ER (Biphasic)

Products Affected

- *tramadol hcl er (biphasic) oral tablet*
extended release 24 hour 100 mg, 200 mg,
300 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tramadol-Acetaminophen

Products Affected

- *tramadol-acetaminophen*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

QL Criteria	30 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trelegy Ellipta

Products Affected

- trelegy ellipta

QL Criteria	2 blisters Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trelstar Mixject

Products Affected

- trelstar mixject

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tremfya

Products Affected

- tremfya

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Tremfya.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 injection Per 56 days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tretinoin

Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Tretinoin Microsphere

Products Affected

- *tretinoin microsphere*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tretinoin Microsphere Pump

Products Affected

- tretinoin microsphere pump*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Dariers disease, Darier-White disease), facial flat warts, and multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: A documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), actinic keratoses and lesions are on the face or lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, keratosis follicularis (Dariers disease, Darier-White disease), facial flat warts, or of multiple flat warts (includes common warts and plantar warts).
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Tretten

Products Affected

- tretten

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Treximet

Products Affected

- treximet

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trezix

Products Affected

- trezix oral capsule 320.5-30-16 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	10 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Triamcinolone Acetonide

Products Affected

- *triamcinolone acetonide nasal aerosol*

QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tribenzor

Products Affected

- tribenzor

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tricor

Products Affected

- tricor

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trientine HCl

Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Triglide

Products Affected

- triglide oral tablet 160 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trilipix

Products Affected

- trilipix

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trintellix

Products Affected

- trintellix

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Triptodur

Products Affected

- triptodur

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Triumeq

Products Affected

- triumeq

QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TriVisc

Products Affected

- trivisc

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trokendi XR

Products Affected

- trokendi xr oral capsule extended release
24 hour 100 mg, 25 mg, 50 mg

QL Criteria	1 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trokendi XR

Products Affected

- trokendi xr oral capsule extended release
24 hour 200 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trospium Chloride

Products Affected

- *trospium chloride*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trospium Chloride ER

Products Affected

- *trospium chloride er*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

True Metrix Blood Glucose Test

Products Affected

- true metrix blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TRUEtest Test

Products Affected

- truetest test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TrueTrack Test

Products Affected

- truetrack test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trulance

Products Affected

- trulance

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Trulicity

Products Affected

- trulicity

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 injections Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tudorza Pressair

Products Affected

- tudorza pressair inhalation aerosol powder
breath activated

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 inhaler Per 1 fill
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

TussiCaps

Products Affected

- tussicaps oral capsule extended release 12 hour 10-8 mg

QL Criteria	20 capsules Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tussionex Pennkinetic ER

Products Affected

- tussionex pennkinetic er oral suspension
extended release

QL Criteria	120 ML Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Twynsta

Products Affected

- twynsta

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tybost

Products Affected

- tybost

QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tykerb

Products Affected

- tykerb

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tylenol with Codeine #3

Products Affected

- tylenol with codeine #3

QL Criteria	12 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tylenol with Codeine #4

Products Affected

- tylenol with codeine #4

QL Criteria	10 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tymlos

Products Affected

- tymlos

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 pen Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tysabri

Products Affected

- tysabri

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Tysabri.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tyvaso

Products Affected

- tyvaso

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 SOLN Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tyvaso Refill

Products Affected

- tyvaso refill

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Tyvaso Starter

Products Affected

- tyvaso starter

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Uceris

Products Affected

- uceris oral

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uceris

Products Affected

- uceris rectal

PA Criteria	Criteria Details
Covered Uses	Active mild to moderate ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of ACTIVE mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge, requiring induction of remission.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of mild to moderate ulcerative colitis AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 canisters Per 1 month
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ulesfia

Products Affected

- ulesfia

QL Criteria	3 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uloric

Products Affected

- uloric

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ultima Test

Products Affected

- ultima test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ultracet

Products Affected

- ultracet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: December 27, 2017

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Ultram

Products Affected

- ultram

QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

UltraTRAK PRO Test

Products Affected

- ultratrak pro test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK Ultimate Test

Products Affected

- ultratrak ultimate test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ultravate

Products Affected

- ultravate external cream
- ultravate external ointment

QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultravate

Products Affected

- ultravate external lotion

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Unistrip1 Generic

Products Affected

- unistrip1 generic

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Uptravi

Products Affected

- uptravi oral tablet 1000 mcg, 1200 mcg, 1400 mcg, 1600 mcg, 400 mcg, 600 mcg, 800 mcg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Uptravi

Products Affected

- uptravi oral tablet 200 mcg
- uptravi oral tablet therapy pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Utibron Neohaler

Products Affected

- utibron neohaler

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Valchlor

Products Affected

- valchlor

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 grams Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Valcyte

Products Affected

- valcyte oral solution reconstituted

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1000 mls Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Valcyte

Products Affected

- valcyte oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	102 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl oral solution reconstituted*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1000 ML Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	102 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Valsartan

Products Affected

- *valsartan*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Valsartan-Hydrochlorothiazide

Products Affected

- *valsartan-hydrochlorothiazide*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vanatol LQ

Products Affected

- vanatol lq

QL Criteria	90 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vanos

Products Affected

- vanos

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vantas

Products Affected

- vantas

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Varubi

Products Affected

- varubi oral

QL Criteria	4 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vascepa

Products Affected

- vascepa oral capsule 0.5 gm

QL Criteria	8 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vascepa

Products Affected

- vascepa oral capsule 1 gm

QL Criteria	4 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vecamyl

Products Affected

- vecamyl

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/antihypertensive_misc.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	10 tabs Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Veletri

Products Affected

- veletri

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Veltassa

Products Affected

- veltassa

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperkalemia
Exclusion Criteria	
Required Medical Information	Documentation that a member (at least 18 years of age) has a diagnosis of chronic kidney disease (CKD) and has hyperkalemia (serum potassium level of 5.1 to greater than 6.5 mEq/L), that the member is stable on an angiotensin converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), or an aldosterone antagonist (e.g. spironolactone, eplerenone)(if taking one of the medications), the patient has been counseled to take all other oral medications 3 hours before or 3 hours after Veltassa, Veltassa will not be used as an emergency treatment for life-threatening hyperkalemia, and the member is following a low potassium diet (less than or equal to 3 grams per day).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Reauthorization criteria: Use of Veltassa has been effective in treating hyperkalemia (e.g. current serum potassium level is lower than the pretreatment baseline serum potassium level), the member continues to require treatment for hyperkalemia, the member is stable on an angiotensin converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), or an aldosterone antagonist (e.g. spironolactone, eplerenone)(if taking one of the medications) and the member continues to follow a low potassium diet (less than or equal to 3 grams per day).
QL Criteria	1 packet Per 1 Day

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Notes/ References	
Revision Date	Prior Authorization: August 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vemlidy

Products Affected

- vemlidy

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Vemlidy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venclexta

Products Affected

- venclexta oral tablet 10 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	40 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venclexta

Products Affected

- venclexta oral tablet 100 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venclexta

Products Affected

- venclexta oral tablet 50 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venclexta Starting Pack

Products Affected

- venclexta starting pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 pack Per 28 days
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

QL Criteria	5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hour 150 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hour 225 mg*

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hour 37.5 mg, 75 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ventavis

Products Affected

- ventavis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Verdeso

Products Affected

- verdeso

QL Criteria	100 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verdrocet

Products Affected

- verdrocet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Versacloz

Products Affected

- versacloz

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Schizoaffective disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia or Schizoaffective disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Schizophrenia or Schizoaffective disorder AND There is clinical documentation indicating disease stability or improvement from baseline
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Verzenio

Products Affected

- verzenio

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOP/Verzenio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

VESIcare

Products Affected

- vesicare

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Viberzi

Products Affected

- viberzi

PA Criteria	Criteria Details
Covered Uses	Diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	No known or suspected history of any of the following: does not have a gallbladder, diagnosis of pancreatitis, diagnosis of alcoholism, member drinks more than 3 alcoholic beverages/day, severe (Child-Pugh C) hepatic impairment, or anatomic or biochemical abnormalities of the gastrointestinal tract (e.g., biliary duct obstruction, sphincter of Oddi dysfunction, or severe constipation)
Required Medical Information	A documented diagnosis of diarrhea-predominant irritable bowel syndrome (IBS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vicodin

Products Affected

- *vicodin oral tablet 5-300 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Vicodin ES

Products Affected

- *vicodin es oral tablet 7.5-300 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	12 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

Vicodin HP

Products Affected

- *vicodin hp oral tablet 10-300 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	9 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Victory AGM-4000 Test

Products Affected

- victory agm-4000 test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Victoza

Products Affected

- victoza subcutaneous solution pen-injector

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 pens Per 30 Days
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Viekira Pak

Products Affected

- viekira pak

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Viekira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Viekira XR

Products Affected

- viekira xr

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Viekira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vigabatrin

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vigadrone

Products Affected

- vigadrone

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Viibryd

Products Affected

- viibryd oral tablet

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vimizim

Products Affected

- vimizim

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vimovo

Products Affected

- vimovo

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vimpat

Products Affected

- vimpat oral solution

QL Criteria	40 ML Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected

- vimpat oral tablet

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Viramune XR

Products Affected

- viramune xr oral tablet extended release 24 hour 100 mg

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viramune XR

Products Affected

- viramune xr oral tablet extended release 24 hour 400 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Viread

Products Affected

- viread oral tablet

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vistogard

Products Affected

- vistogard

QL Criteria	20 packs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Visudyne

Products Affected

- visudyne

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/EYE/opthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vivelle-Dot

Products Affected

- vivelle-dot

QL Criteria	8 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vivlodex

Products Affected

- vivlodex

PA Criteria	Criteria Details
Covered Uses	Management of osteoarthritis (OA) pain
Exclusion Criteria	
Required Medical Information	A documented diagnosis of osteoarthritis (OA) pain
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vizimpro

Products Affected

- vizimpro

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/vizimpro.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vocal Point Blood Glucose Test

Products Affected

- vocal point blood glucose test

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vogelxo

Products Affected

- vogelxo transdermal gel 50 mg/5gm (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	10 grams Per 1 Day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vogelxo Pump

Products Affected

- vogelxo pump

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purpose.
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratorys reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratorys reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) (Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Testosterone levels are in normal range
QL Criteria	10 grams Per 1 Day
Notes/References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Voltaren

Products Affected

- voltaren transdermal

QL Criteria	200 GM Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vonvendi

Products Affected

- vonvendi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vosevi

Products Affected

- vosevi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Vosevi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Votrient

Products Affected

- votrient

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vpriv

Products Affected

- vpriv

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vraylar

Products Affected

- vraylar oral capsule 1.5 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Manic or mixed episodes associated with bipolar I disorder in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	4 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vraylar

Products Affected

- vraylar oral capsule 3 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Manic or mixed episodes associated with bipolar I disorder in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 capsule Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vraylar

Products Affected

- vraylar oral capsule 4.5 mg, 6 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Manic or mixed episodes associated with bipolar I disorder in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 capsule Per 1 day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vraylar

Products Affected

- vraylar oral capsule therapy pack

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Manic or mixed episodes associated with bipolar I disorder in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults AND There is clinical documentation indicating disease stability or improvement from baseline
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vytorin

Products Affected

- vytorin

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyvanse

Products Affected

- vyvanse oral capsule

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Vyvanse

Products Affected

- vyvanse oral tablet chewable

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyzulta

Products Affected

- vyzulta

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

WaveSense Presto

Products Affected

- wavesense presto

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wellbutrin SR

Products Affected

- wellbutrin sr

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Wellbutrin XL

Products Affected

- wellbutrin xl

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Wilate

Products Affected

- wilate intravenous kit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xadago

Products Affected

- xadago

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xalatan

Products Affected

- xalatan

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xalkori

Products Affected

- xalkori

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xanax XR

Products Affected

- xanax xr

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xarelto

Products Affected

- xarelto oral tablet 10 mg, 20 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto

Products Affected

- xarelto oral tablet 15 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xarelto

Products Affected

- xarelto oral tablet 2.5 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto Starter Pack

Products Affected

- xarelto starter pack

QL Criteria	1 pack Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xatmep

Products Affected

- xatmep

PA Criteria	Criteria Details
Covered Uses	Treatment of acute lymphoblastic leukemia (ALL) or polyarticular juvenile idiopathic arthritis (pJIA) in pediatric patients
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Acute Lymphoblastic Leukemia (ALL) in a pediatric patient (18 years and younger) as part of a multi-phase, combination chemotherapy maintenance regimen or a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA) in pediatric patients (18 years and younger) who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs). Regardless of diagnosis, the patient must have a documented inability to swallow tablets/capsules.
Age Restrictions	Approved for those 18 years of age or younger
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: July 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xeljanz

Products Affected

- xeljanz

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xeljanz XR

Products Affected

- xeljanz xr

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xeloda

Products Affected

- xeloda

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xenazine

Products Affected

- xenazine oral tablet 12.5 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xenazine

Products Affected

- xenazine oral tablet 25 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xeomin

Products Affected

- xeomin

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xepi

Products Affected

- xepi

QL Criteria	1 tube Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xermelo

Products Affected

- xermelo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Xermelo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xgeva

Products Affected

- xgeva

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xhance

Products Affected

- xhance

PA Criteria	Criteria Details
Covered Uses	Treatment of nasal polyps in patients 18 years of age or older
Exclusion Criteria	Hypersensitivity to any ingredient in Xhance
Required Medical Information	A documented diagnosis of nasal polyps
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: Treatment of nasal polyps in patients 18 years of age or older AND there is clinical documentation indicating disease stability or improvement from baseline (e.g., improvement in nasal congestion or obstruction, reduction of bilateral polyp grade).
QL Criteria	1 inhaler Per 30 Days
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xifaxan

Products Affected

- xifaxan oral tablet 200 mg

QL Criteria	9 tablets Per 1 fill
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xifaxan

Products Affected

- xifaxan oral tablet 550 mg

PA Criteria	Criteria Details
Covered Uses	Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea.
Exclusion Criteria	
Required Medical Information	FOR HEPATIC ENCEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xigduo XR

Products Affected

- xigduo xr oral tablet extended release 24 hour 2.5-1000 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xigduo XR

Products Affected

- xigduo xr oral tablet extended release 24 hour 5-1000 mg

QL Criteria	2 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xodol

Products Affected

- xodol oral tablet 5-300 mg, 7.5-300 mg

QL Criteria	12 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xolair

Products Affected

- xolair

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/RESP/Xolair.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xolegel

Products Affected

- xolegel

QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xopenex HFA

Products Affected

- xopenex hfa

QL Criteria	2 inhalers Per 1 fill
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xtampza ER

Products Affected

- xtampza er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

PA Criteria	Criteria Details
Other Criteria	<p>A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.</p>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	<p>Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xtandi

Products Affected

- xtandi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xultophy

Products Affected

- xultophy

QL Criteria	5 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xuriden

Products Affected

- xuriden

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xyntha

Products Affected

- xyntha intravenous kit 1000 unit, 2000 unit, 250 unit, 500 unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xyntha Solofuse

Products Affected

- xyntha solofuse

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Xyrem

Products Affected

- xyrem

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/cataplaxy-xyrem.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Yervoy

Products Affected

- yervoy

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/yervoy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Yonsa

Products Affected

- yonsa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Yonsa.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Yosprala

Products Affected

- yosprala

PA Criteria	Criteria Details
Covered Uses	Documented history of cardiovascular or cerebrovascular events
Exclusion Criteria	
Required Medical Information	A documented history of cardiovascular or cerebrovascular events in a patient greater than 55 years of age or a patient who has a documented history of gastric ulcers
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zafirlukast

Products Affected

- *zafirlukast*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zaleplon

Products Affected

- *zaleplon*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zarxio

Products Affected

- zarxio

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zavesca

Products Affected

- zavesca

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zegerid

Products Affected

- zegerid oral capsule 40-1100 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zegerid

Products Affected

- zegerid oral packet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 pack Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

Zegerid OTC

Products Affected

- zegerid otc

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zejula

Products Affected

- zejula

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Zejula.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zelapar

Products Affected

- zelapar

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zelboraf

Products Affected

- zelboraf

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zemaira

Products Affected

- zemaira

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zembrace SymTouch

Products Affected

- zembrace symtouch

QL Criteria	8 syringes/1 month Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zemplar

Products Affected

- zemplar oral capsule 1 mcg, 2 mcg

QL Criteria	1 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenatane

Products Affected

- *zenatane oral capsule 10 mg, 20 mg, 40 mg* • zenatane oral capsule 30 mg

PA Criteria	Criteria Details
Covered Uses	Severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member is enrolled in the FDA iPLEDGE program and, because of significant adverse reactions associated with its use, should be reserved for patients with multiple severe nodular acne who are unresponsive to conventional therapy, including topical acne products and systemic antibiotics. Treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zenzedi

Products Affected

- zenzedi oral tablet 10 mg, 5 mg

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenzedi

Products Affected

- zenzedi oral tablet 15 mg, 2.5 mg, 20 mg, 30 mg, 7.5 mg

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zepatier

Products Affected

- zepatier

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Zepatier.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zetia

Products Affected

- zetia

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zileuton ER

Products Affected

- *zileuton er*

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zioptan

Products Affected

- zioptan

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Ziprasidone HCl

Products Affected

- *ziprasidone hcl*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zocor

Products Affected

- ZOCOR

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zohydro ER

Products Affected

- zohydro er oral capsule er 12 hour abuse-deterrent

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month.</p>
Age Restrictions	
Prescriber Restrictions	

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
 The formulary is updated the first week of each month.
 12/01/2018

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf . ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf , https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm , and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf .
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zoladex

Products Affected

- zoladex

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zolinza

Products Affected

- zolinza

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ZOLMitriptan

Products Affected

- *zolmitriptan oral*

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoloft

Products Affected

- zoloft oral tablet 100 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zoloft

Products Affected

- zoloft oral tablet 25 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoloft

Products Affected

- zoloft oral tablet 50 mg

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate oral*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate sublingual*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- zomig nasal solution 2.5 mg

QL Criteria	6 sprays Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zomig

Products Affected

- zomig nasal solution 5 mg

QL Criteria	6 sprays Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- zomig oral

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zomig ZMT

Products Affected

- zomig zmt

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zonalon

Products Affected

- zonalon

QL Criteria	45 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zontivity

Products Affected

- zontivity

PA Criteria	Criteria Details
Covered Uses	Reduction of the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD)
Exclusion Criteria	Do not use in patients with history of stroke, history of transient ischemic attack (TIA), or history of intracranial hemorrhage (ICH), or active pathological bleeding
Required Medical Information	Documented diagnosis or history of myocardial infarction (MI) or peripheral arterial disease (PAD) and concurrent use of aspirin or clopidogrel.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zorbtive

Products Affected

- zorbtive

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zorvolex

Products Affected

- zorvolex

PA Criteria	Criteria Details
Covered Uses	Management of osteoarthritis (OA) pain, Management of mild to moderate acute pain
Exclusion Criteria	
Required Medical Information	A documented diagnosis of osteoarthritis (OA) pain OR a documented diagnosis of mild to moderate acute pain
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	3 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ZTlido

Products Affected

- ztlido

PA Criteria	Criteria Details
Covered Uses	Neuropathic pain (i.e. post herpetic neuralgia).
Exclusion Criteria	
Required Medical Information	A documented diagnosis of neuropathic pain (i.e. post herpetic neuralgia).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	3 pads Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: November 25, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zubsolv

Products Affected

- zubsolv sublingual tablet sublingual 0.7-0.18 mg

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zubsolv

Products Affected

- zubsolv sublingual tablet sublingual 1.4-0.36 mg, 11.4-2.9 mg, 2.9-0.71 mg, 5.7-1.4 mg, 8.6-2.1 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zurampic

Products Affected

- zurampic

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperuricemia associated with gout
Exclusion Criteria	
Required Medical Information	A documented diagnosis of gout, and will be used in combination with a xanthine oxidase inhibitor (allopurinol OR febuxostat)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zyban

Products Affected

- zyban

QL Criteria	2 tablet Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zyclara

Products Affected

- zyclara

QL Criteria	56 grams Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyclara Pump

Products Affected

- zyclara pump external cream 2.5 %

QL Criteria	2 bottle Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zyclara Pump

Products Affected

- zyclara pump external cream 3.75 %

QL Criteria	30 packets Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zydelig

Products Affected

- zydelig

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zyflo

Products Affected

- zyflo

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyflo CR

Products Affected

- zyflo cr

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zykadia

Products Affected

- zykadia

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	5 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zypitamag

Products Affected

- zypitamag

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: May 30, 2018

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ZyPREXA

Products Affected

- zyprexa oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ZyPREXA

Products Affected

- zyprexa oral tablet 2.5 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

ZyPREXA Zydis

Products Affected

- zyprexa zydis

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zytiga

Products Affected

- zytiga oral tablet 250 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zytiga

Products Affected

- zytiga oral tablet 500 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zyvox

Products Affected

- zyvox oral suspension reconstituted

QL Criteria	150 MLS Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

Zyvox

Products Affected

- zyvox oral tablet

QL Criteria	28 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Index

abilify oral tablet.....	1	adderall xr.....	46
absorica.....	2	<i>adefovir dipivoxil</i>	47
abstral.....	3	adempas.....	48
<i>acamprosate calcium</i>	5	adlyxin.....	49
accolate.....	6	adlyxin starter pack.....	50
accu-chek aviva plus in vitro.....	7	advair diskus inhalation aerosol powder breath activated 100-50 mcg/dose, 250- 50 mcg/dose.....	51
accu-chek compact plus.....	8	advair diskus inhalation aerosol powder breath activated 500-50 mcg/dose.....	52
accu-chek multiclix lancet dev.....	9	advair hfa.....	53
accu-chek smartview.....	10	advance intuition test.....	54
accutrend glucose.....	11	advance micro-draw test.....	55
<i>acetaminophen-codeine #2</i>	18	advate.....	56
<i>acetaminophen-codeine #3</i>	20	advocate duo device.....	57
<i>acetaminophen-codeine #4</i>	22	advocate redi-code in vitro.....	58
<i>acetaminophen-codeine oral solution</i>	12	advocate redi-code+ test.....	59
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	14	advocate test.....	60
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	16	adynovate.....	61
aciphex.....	24	adyphren.....	62
aciphex sprinkle.....	25	adyphren amp ii.....	63
<i>acitretin</i>	26	adyphren ii.....	64
actemra intravenous.....	27	adzenys er.....	65
actemra subcutaneous.....	28	adzenys xr-odt.....	66
actimmune.....	29	<i>afeditab cr oral tablet extended release 24 hour 30 mg</i>	67
actiq.....	30	<i>afeditab cr oral tablet extended release 24 hour 60 mg</i>	68
activella.....	32	afinitor.....	69
actonel oral tablet 150 mg.....	33	afinitor disperz.....	70
actonel oral tablet 30 mg, 5 mg.....	34	afrezza inhalation powder 12 unit, 8 unit.....	71
actonel oral tablet 35 mg.....	35	afrezza inhalation powder 4 & 8 & 12 unit, 4 (90) & 8 (90) unit, 4 unit.....	72
actoplus met.....	36	afstyla.....	73
actoplus met xr.....	37	agamatrix amp test.....	74
actos.....	38	agamatrix jazz test.....	75
aczone.....	39	agamatrix keynote test.....	76
adagen.....	40	agamatrix presto test.....	77
adalat cc oral tablet extended release 24 hour 30 mg, 90 mg.....	41	aimovig.....	78
adalat cc oral tablet extended release 24 hour 60 mg.....	42	aimovig 140 dose.....	79
<i>adapalene external solution</i>	43	airduo respiclick 113/14.....	80
adcirca.....	44		
adderall.....	45		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

airduo respiclick 232/14.....	81	<i>amphetamine sulfate</i>	122
airduo respiclick 55/14.....	82	<i>amphetamine-dextroamphet er</i>	123
ajovy.....	83	<i>amphetamine-dextroamphetamine</i>	124
akynzeo oral.....	84	ampyra.....	125
<i>albendazole oral</i>	85	androderm transdermal patch 24 hour ...	126
albenza.....	86	androgel pump transdermal gel 20.25	
aldara.....	87	mg/act (1.62%).....	134
aldurazyme.....	88	androgel transdermal gel 20.25	
alecensa.....	89	mg/1.25gm (1.62%), 40.5 mg/2.5gm	
<i>alendronate sodium oral tablet 10 mg, 40</i>		(1.62%).....	128
<i>mg, 5 mg</i>	90	androgel transdermal gel 25 mg/2.5gm	
<i>alendronate sodium oral tablet 35 mg</i>	91	(1%).....	130
<i>alendronate sodium oral tablet 70 mg</i>	92	androgel transdermal gel 50 mg/5gm	
<i>alfuzosin hcl er</i>	93	(1%).....	132
alinia oral suspension reconstituted.....	94	anoro ellipta.....	136
alinia oral tablet.....	95	antara oral capsule 30 mg, 90 mg.....	137
<i>almotriptan malate</i>	96	anzemet oral.....	138
<i>alogliptin benzoate</i>	97	<i>apap-caff-dihydrocodeine oral capsule</i>	139
<i>alogliptin-metformin hcl</i>	98	<i>apap-caff-dihydrocodeine oral tablet 325-</i>	
<i>alogliptin-pioglitazone</i>	99	<i>30-16 mg</i>	141
alora.....	100	aplenzin.....	142
<i>alosetron hcl</i>	101	<i>aprepitant oral capsule 125 mg, 40 mg, 80</i>	
alphanate/vwf complex/human.....	102	<i>mg</i>	143
alphanine sd.....	103	<i>aprepitant oral capsule 80 & 125 mg</i>	144
<i>alprazolam er</i>	104	apriso.....	145
<i>alprazolam xr</i>	105	aptensio xr.....	146
alprolix.....	106	aptiom oral tablet 200 mg, 600 mg.....	147
altoprev.....	107	aptiom oral tablet 400 mg, 800 mg.....	148
altreno.....	108	aralast np intravenous solution	
alunbrig oral tablet 180 mg, 90 mg.....	110	reconstituted 1000 mg, 500 mg.....	149
alunbrig oral tablet 30 mg.....	111	aranesp (albumin free) injection solution	
alunbrig oral tablet therapy pack.....	110	100 mcg/ml, 200 mcg/ml, 25 mcg/ml, 300	
alvesco.....	112	mcg/ml, 40 mcg/ml, 60 mcg/ml.....	150
ambien.....	113	aranesp (albumin free) injection solution	
ambien cr.....	114	prefilled syringe 100 mcg/0.5ml, 150	
amerge.....	115	mcg/0.3ml, 200 mcg/0.4ml, 25	
amitiza.....	116	mcg/0.42ml, 300 mcg/0.6ml, 40	
<i>amlodipine besylate-valsartan</i>	117	mcg/0.4ml, 500 mcg/ml, 60 mcg/0.3ml....	150
<i>amlodipine-atorvastatin</i>	118	arava.....	151
<i>amlodipine-olmesartan</i>	119	arcalyst.....	152
<i>amlodipine-valsartan-hctz</i>	120	arcapta neohaler.....	153
<i>amnesteem</i>	121	aricept.....	154

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>aripiprazole oral solution</i>	155	<i>atazanavir sulfate oral capsule 150 mg,</i>	
<i>aripiprazole oral tablet</i>	156	<i>300 mg</i>	192
<i>aripiprazole oral tablet dispersible</i>	156	<i>atazanavir sulfate oral capsule 200 mg</i>	193
<i>arixtra</i>	157	<i>atelvia</i>	194
<i>armodafinil oral tablet 150 mg, 200 mg,</i>		<i>atomoxetine hcl oral capsule 10 mg, 18</i>	
<i>250 mg</i>	158	<i>mg, 25 mg, 40 mg, 60 mg</i>	195
<i>armodafinil oral tablet 50 mg</i>	160	<i>atomoxetine hcl oral capsule 100 mg, 80</i>	
<i>armonair respiclick 113</i>	162	<i>mg</i>	196
<i>armonair respiclick 232</i>	163	<i>atorvastatin calcium oral</i>	197
<i>armonair respiclick 55</i>	164	<i>atralin</i>	198
<i>arnuity ellipta inhalation aerosol powder</i>		<i>atripla</i>	199
<i>breath activated 100 mcg/act, 200</i>		<i>atrovent hfa</i>	200
<i>mcg/act</i>	165	<i>aubagio</i>	201
<i>arnuity ellipta inhalation aerosol powder</i>		<i>austedo</i>	202
<i>breath activated 50 mcg/act</i>	166	<i>auvi-q injection solution auto-injector</i>	
<i>arymo er oral tablet extended release</i>		<i>0.1 mg/0.1ml</i>	203
<i>abuse-deterrent 15 mg, 30 mg</i>	167	<i>auvi-q injection solution auto-injector</i>	
<i>arymo er oral tablet extended release</i>		<i>0.15 mg/0.15ml, 0.3 mg/0.3ml</i>	204
<i>abuse-deterrent 60 mg</i>	169	<i>avalide oral tablet 150-12.5 mg, 300-12.5</i>	
<i>arzerra</i>	171	<i>mg</i>	205
<i>asacol hd</i>	172	<i>avandia oral tablet 2 mg, 4 mg</i>	206
<i>ascomp-codeine</i>	173	<i>avapro</i>	207
<i>asmanex 120 metered doses</i>	175	<i>avita</i>	208
<i>asmanex 14 metered doses</i>	176	<i>avodart</i>	209
<i>asmanex 30 metered doses</i>	177	<i>avonex</i>	210
<i>asmanex 60 metered doses</i>	178	<i>avonex pen intramuscular auto-injector</i>	
<i>asmanex 7 metered doses</i>	179	<i>kit</i>	211
<i>asmanex hfa</i>	180	<i>avonex prefilled intramuscular prefilled</i>	
<i>assure 3 test</i>	181	<i>syringe kit</i>	212
<i>assure 4 test</i>	182	<i>azilect</i>	213
<i>assure ii</i>	183	<i>azor</i>	214
<i>assure ii check</i>	184	<i>azulfidine</i>	215
<i>assure platinum</i>	185	<i>azulfidine en-tabs</i>	216
<i>assure prism multi test</i>	186	<i>bactroban external cream</i>	217
<i>assure pro test</i>	187	<i>balsalazide disodium</i>	218
<i>astagraf xl oral capsule extended release</i>		<i>banzel oral tablet</i>	219
<i>24 hour 0.5 mg</i>	188	<i>baraclude oral tablet</i>	220
<i>astagraf xl oral capsule extended release</i>		<i>baxdela oral</i>	221
<i>24 hour 1 mg</i>	189	<i>bayer breeze 2 test</i>	222
<i>atacand oral tablet 16 mg, 4 mg, 8 mg</i>	190	<i>bayer contour test</i>	223
<i>atacand oral tablet 32 mg</i>	191	<i>bebulin</i>	224
		<i>belbuca</i>	225

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

belsomra.....	227	briviact oral solution.....	263
benefix intravenous kit.....	228	briviact oral tablet.....	264
benicar.....	229	brovana.....	265
benicar hct.....	230	<i>budesonide er oral tablet extended release</i>	
benlysta intravenous.....	231	<i>24 hour.....</i>	267
benlysta subcutaneous.....	232	<i>budesonide inhalation.....</i>	266
<i>benznidazole oral tablet 100 mg.....</i>	233	bunavail buccal film 2.1-0.3 mg.....	268
<i>benznidazole oral tablet 12.5 mg.....</i>	234	bunavail buccal film 4.2-0.7 mg, 6.3-1	
berinert.....	235	mg.....	269
<i>betamethasone dipropionate aug external</i>		buphenyl oral powder 3 gm/tsp.....	270
<i>gel.....</i>	236	buphenyl oral tablet.....	270
<i>betamethasone dipropionate aug external</i>		<i>buprenorphine.....</i>	271
<i>lotion.....</i>	237	<i>buprenorphine hcl sublingual.....</i>	273
<i>betamethasone dipropionate aug external</i>		<i>buprenorphine hcl-naloxone hcl sublingual</i>	
<i>ointment.....</i>	236	<i>tablet sublingual.....</i>	274
betaseron subcutaneous kit.....	238	<i>bupropion hcl er (smoking det).....</i>	276
bethkis.....	239	<i>bupropion hcl er (sr).....</i>	277
bevespi aerosphere.....	240	<i>bupropion hcl er (xl) oral tablet extended</i>	
bevyxxa.....	241	<i>release 24 hour 150 mg, 300 mg.....</i>	278
<i>bexarotene.....</i>	242	<i>bupropion hcl er (xl) oral tablet extended</i>	
<i>bicalutamide.....</i>	243	<i>release 24 hour 450 mg.....</i>	279
biktarvy.....	244	<i>bupropion hcl oral.....</i>	275
<i>bimatoprost ophthalmic.....</i>	245	<i>butalbital-apap-caff-cod.....</i>	280
binosto.....	246	<i>butalbital-asa-caff-codeine.....</i>	282
bioscanner glucose test.....	247	<i>butorphanol tartrate nasal.....</i>	284
bivigam.....	248	butrans.....	286
<i>blood glucose test.....</i>	249	bydureon bcise.....	290
boniva oral tablet 150 mg.....	250	bydureon subcutaneous pen-injector.....	288
bonjesta.....	251	bydureon subcutaneous suspension	
bosulif oral tablet 100 mg.....	252	reconstituted er.....	289
bosulif oral tablet 400 mg, 500 mg.....	253	byetta 10 mcg pen subcutaneous solution	
botox.....	254	pen-injector.....	291
braftovi oral capsule 50 mg.....	255	byetta 5 mcg pen subcutaneous solution	
braftovi oral capsule 75 mg.....	256	pen-injector.....	292
bravelle.....	257	bystolic oral tablet 10 mg, 2.5 mg, 5 mg.....	293
breo ellipta inhalation aerosol powder		bystolic oral tablet 20 mg.....	294
breath activated 100-25 mcg/inh.....	258	byvalson.....	295
breo ellipta inhalation aerosol powder		cabometyx.....	296
breath activated 200-25 mcg/inh.....	259	caduet oral tablet 10-10 mg, 10-20 mg,	
brilinta oral tablet 60 mg.....	260	10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg,	
brilinta oral tablet 90 mg.....	261	5-40 mg, 5-80 mg.....	297
brisdelle.....	262	<i>calcipotriene-betameth diprop.....</i>	298

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>calcitonin (salmon)</i>	299	cerezyme intravenous solution	
calquence	300	reconstituted 400 unit	331
cambia	301	cesamet	332
canasa	302	cetrotide subcutaneous kit 0.25 mg	333
<i>candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg</i>	303	<i>cevimeline hcl</i>	334
<i>candesartan cilexetil-hctz</i>	304	chantix	335
<i>capecitabine</i>	305	chantix continuing month pak	336
capex	306	chenodal	337
caprelsa oral tablet 100 mg	307	cholbam	339
caprelsa oral tablet 300 mg	308	<i>chorionic gonadotropin intramuscular</i>	340
carbagli	309	ciclodan external solution	341
<i>carbinoxamine maleate oral tablet 6 mg</i> ..	310	<i>ciclopirox external solution</i>	342
cardizem cd oral capsule extended		cimduo	343
release 24 hour 120 mg, 180 mg, 360 mg	311	cimzia prefilled	345
cardizem cd oral capsule extended		cimzia starter kit	346
release 24 hour 240 mg	312	cimzia subcutaneous kit 2 x 200 mg	344
cardizem la oral tablet extended release		cinqair	347
24 hour 120 mg	313	cinryze	348
cardizem la oral tablet extended release		<i>citalopram hydrobromide oral tablet 10 mg, 20 mg</i>	349
24 hour 180 mg, 300 mg, 360 mg	314	<i>citalopram hydrobromide oral tablet 40 mg</i>	350
cardizem la oral tablet extended release		<i>claravis</i>	351
24 hour 240 mg	315	clarinex oral tablet	352
cardura xl	316	clarinex-d 12 hour	353
caresens n glucose test	317	clever chek auto-code	354
carimune nf intravenous solution		clever chek auto-code test	355
reconstituted 12 gm, 6 gm	318	clever chek auto-code voice in vitro	356
carospir	319	clever chek test	357
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg</i>	320	clever choice auto-code test	358
<i>cartia xt oral capsule extended release 24 hour 240 mg</i>	321	clever choice micro test	359
<i>carvedilol phosphate er</i>	322	climara	360
casodex	323	climara pro	361
cayston	324	<i>clobetasol propionate e</i>	366
celebrex	325	<i>clobetasol propionate emulsion</i>	367
<i>celecoxib oral</i>	326	<i>clobetasol propionate external cream</i>	362
celexa oral tablet 10 mg, 20 mg	327	<i>clobetasol propionate external foam</i>	363
celexa oral tablet 40 mg	328	<i>clobetasol propionate external gel</i>	362
centany	329	<i>clobetasol propionate external liquid</i>	364
cerdelga	330	<i>clobetasol propionate external lotion</i>	365
		<i>clobetasol propionate external ointment</i> ..	362
		<i>clobetasol propionate external shampoo</i> ..	365

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>clobetasol propionate external solution</i>	363	coreg cr	407
clobex	368	coremino	408
clobex spray	369	corifact	409
<i>clodan external shampoo</i>	370	corlanor	410
<i>clonidine hcl er</i>	371	cortifoam	411
<i>clopidogrel bisulfate oral</i>	372	cosentyx	412
<i>clozapine oral tablet 100 mg</i>	373	cosentyx sensoready pen subcutaneous solution auto-injector 150 mg/ml	413
<i>clozapine oral tablet 200 mg</i>	374	cotellic	414
<i>clozapine oral tablet 25 mg, 50 mg</i>	375	cotempla xr-odt	415
<i>clozapine oral tablet dispersible 100 mg</i> ..	373	cozaar oral tablet 25 mg, 50 mg	416
<i>clozapine oral tablet dispersible 12.5 mg</i> ..	376	crestor	417
<i>clozapine oral tablet dispersible 150 mg</i> ..	377	cuprimine oral capsule 250 mg	418
<i>clozapine oral tablet dispersible 200 mg</i> ..	378	cuvitru	419
<i>clozapine oral tablet dispersible 25 mg</i>	375	cvs advanced glucose test	420
clozaril oral tablet 100 mg	379	<i>cvs nicotine polacrilex mouth/throat lozenge 4 mg</i>	422
clozaril oral tablet 25 mg	380	<i>cvs nicotine transdermal patch 24 hour 14 mg/24hr, 7 mg/24hr</i>	421
coagadex	381	cycloset	423
<i>codeine sulfate oral tablet 15 mg</i>	382	cymbalta oral capsule delayed release particles 20 mg	424
<i>codeine sulfate oral tablet 30 mg</i>	384	cymbalta oral capsule delayed release particles 30 mg, 60 mg	425
<i>codeine sulfate oral tablet 60 mg</i>	386	cystagon	426
colazal	388	cystaran	427
<i>colchicine oral</i>	389	daklinza oral tablet 30 mg, 60 mg	428
colcrys	390	daklinza oral tablet 90 mg	429
combipatch	391	<i>dalfampridine er</i>	430
combivent respimat	392	daliresp oral tablet 250 mcg	431
cometriq (100 mg daily dose)	393	daliresp oral tablet 500 mcg	432
cometriq (140 mg daily dose)	394	<i>dapsone external</i>	433
cometriq (60 mg daily dose)	395	<i>darifenacin hydrobromide er</i>	434
complera	396	daytrana	435
concerta oral tablet extended release 18 mg, 27 mg, 54 mg	397	delstrigo	436
concerta oral tablet extended release 36 mg	398	delzicol	437
conzip	399	depen titratabs	438
cool blood glucose test strips	401	descovy	439
copaxone subcutaneous solution prefilled syringe	402	<i>desloratadine oral tablet</i>	440
copiktra	403	<i>desloratadine oral tablet dispersible 2.5 mg</i>	440
cordran external cream 0.05 %	404	desoxyn	441
cordran external lotion	404		
cordran external ointment	405		
cordran external tape	406		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>desvenlafaxine er</i>	442	<i>diltiazem hcl er coated beads oral capsule</i>	
<i>desvenlafaxine succinate er</i>	443	<i>extended release 24 hour 180 mg, 300 mg</i>	478
detrol la.....	444	<i>diltiazem hcl er coated beads oral capsule</i>	
dexedrine oral capsule extended release		<i>extended release 24 hour 240 mg</i>	479
24 hour 10 mg, 15 mg.....	445	<i>diltiazem hcl er oral capsule extended</i>	
dexedrine oral capsule extended release		<i>release 24 hour 240 mg</i>	474
24 hour 5 mg.....	446	<i>dilt-xr oral capsule extended release 24</i>	
dexilant.....	447	<i>hour 240 mg</i>	480
<i>dexmethylphenidate hcl</i>	448	diovan.....	481
<i>dexmethylphenidate hcl er oral capsule</i>		diovan hct.....	482
<i>extended release 24 hour 10 mg, 15 mg,</i>		dipentum.....	483
<i>30 mg, 40 mg, 5 mg</i>	449	diprolene external lotion.....	484
<i>dexmethylphenidate hcl er oral capsule</i>		diprolene external ointment.....	485
<i>extended release 24 hour 20 mg</i>	450	ditropan xl oral tablet extended release	
<i>dexmethylphenidate hcl er oral capsule</i>		24 hour 10 mg.....	486
<i>extended release 24 hour 25 mg, 35 mg</i>	451	ditropan xl oral tablet extended release	
<i>dextroamphetamine sulfate er</i>	454	24 hour 5 mg.....	487
<i>dextroamphetamine sulfate oral solution</i>	452	dolophine oral tablet 10 mg.....	488
<i>dextroamphetamine sulfate oral tablet</i>	453	dolophine oral tablet 5 mg.....	491
diastat acudial.....	455	<i>donepezil hcl</i>	494
diastat pediatric.....	456	doptelet oral tablet 20 mg.....	495
<i>diatrue plus test</i>	457	<i>doxepin hcl external</i>	496
<i>diazepam rectal</i>	458	<i>doxercalciferol oral</i>	497
dibenzyline.....	459	<i>doxycycline</i>	498
diclegis.....	460	<i>doxycycline monohydrate oral capsule</i>	
<i>diclofenac sodium transdermal gel 1 %</i>	461	<i>150 mg</i>	499
<i>diclofenac sodium transdermal gel 3 %</i>	462	<i>doxycycline monohydrate oral capsule 75</i>	
<i>diclofenac sodium transdermal solution</i> ...	463	<i>mg</i>	500
dificid.....	464	<i>dronabinol</i>	501
<i>dihydroergotamine mesylate nasal</i>	465	duavee.....	502
dilaudid oral liquid.....	466	duetact.....	503
dilaudid oral tablet 2 mg.....	468	duexis.....	504
dilaudid oral tablet 4 mg.....	470	dulera.....	505
dilaudid oral tablet 8 mg.....	472	<i>duloxetine hcl oral capsule delayed release</i>	
<i>diltiazem hcl er beads oral capsule</i>		<i>particles 20 mg</i>	506
<i>extended release 24 hour 120 mg, 180 mg,</i>		<i>duloxetine hcl oral capsule delayed release</i>	
<i>300 mg, 360 mg, 420 mg</i>	475	<i>particles 30 mg, 40 mg, 60 mg</i>	507
<i>diltiazem hcl er beads oral capsule</i>		duo-care test.....	508
<i>extended release 24 hour 240 mg</i>	476	duopa enteral.....	509
<i>diltiazem hcl er coated beads oral capsule</i>		dupixent subcutaneous solution prefilled	
<i>extended release 24 hour 120 mg, 360 mg</i>	477	syringe 300 mg/2ml.....	510
		duragesic-100.....	511

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

duragesic-12.....	513	<i>eletriptan hydrobromide</i>	554
duragesic-25.....	515	elidel.....	555
duragesic-50.....	517	eligard.....	556
duragesic-75.....	519	eliquis oral tablet 2.5 mg.....	557
durolane intra-articular.....	521	eliquis oral tablet 5 mg.....	558
<i>dutasteride oral</i>	522	eliquis starter pack.....	559
dutoprol oral tablet extended release 24 hour 100-12.5 mg.....	523	elmiron.....	560
dutoprol oral tablet extended release 24 hour 25-12.5 mg.....	524	eloctate.....	561
dutoprol oral tablet extended release 24 hour 50-12.5 mg.....	525	embeda oral capsule extended release 100-4 mg, 50-2 mg, 60-2.4 mg, 80-3.2 mg	562
duzallo.....	526	embeda oral capsule extended release 20- 0.8 mg, 30-1.2 mg.....	564
dyanavel xr.....	527	embrace blood glucose test.....	566
dysport.....	528	embrace evo blood glucose test.....	567
<i>easy plus ii glucose test</i>	529	embrace pro glucose test.....	568
easy step test.....	530	emend oral capsule 125 mg, 40 mg, 80 mg.....	569
<i>easy talk blood glucose test</i>	531	emflaza oral suspension.....	570
easy touch healthpro test.....	532	emflaza oral tablet.....	571
easy touch test.....	533	emgality.....	572
<i>easy trak blood glucose test</i>	534	emsam.....	573
easygluco in vitro.....	535	emtriva oral capsule.....	574
easygluco plus in vitro.....	536	emverm.....	575
easymax 15 test.....	537	enablex oral tablet extended release 24 hour 15 mg.....	576
easymax test.....	538	enablex oral tablet extended release 24 hour 7.5 mg.....	577
<i>easyplus blood glucose test</i>	539	enbrel mini.....	581
easypro blood glucose test.....	540	enbrel subcutaneous solution prefilled syringe 25 mg/0.5ml.....	578
easypro plus in vitro.....	541	enbrel subcutaneous solution prefilled syringe 50 mg/ml.....	579
<i>econazole nitrate external</i>	542	enbrel subcutaneous solution reconstituted.....	580
edarbi.....	543	enbrel sureclick subcutaneous solution auto-injector.....	582
edarbyclor.....	544	endari.....	583
edurant.....	545	<i>endocet oral tablet 10-325 mg</i>	584
effexor xr oral capsule extended release 24 hour 150 mg.....	546	endocet oral tablet 2.5-325 mg.....	586
effexor xr oral capsule extended release 24 hour 37.5 mg, 75 mg.....	547	<i>endocet oral tablet 5-325 mg</i>	586
effient.....	548	<i>endocet oral tablet 7.5-325 mg</i>	588
elaprase.....	549		
eleyso.....	550		
<i>element compact test</i>	551		
element test.....	552		
elestrin.....	553		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>enoxaparin sodium</i>	590	evamist.....	623
enstilar.....	591	evekeo.....	624
<i>entecavir</i>	592	evencare + blood glucose test.....	625
entresto.....	593	evencare blood glucose test.....	626
entyvio.....	594	evencare g2 test.....	627
epaned oral solution.....	595	evencare g3 test.....	628
epclusa.....	596	evencare mini glucose test.....	629
epidiolex.....	597	evolution autocode in vitro.....	630
<i>epinephrine injection solution auto-injector</i>	598	evoxac.....	631
epipen 2-pak injection solution auto-injector.....	599	evzio injection solution auto-injector 2 mg/0.4ml.....	632
epipen jr 2-pak injection solution auto-injector.....	600	exalgo oral tablet er 24 hour abuse-deterrent.....	633
episnap.....	601	exelderm.....	635
epogen injection solution 10000 unit/ml, 2000 unit/ml, 20000 unit/ml, 3000 unit/ml, 4000 unit/ml.....	602	exelon transdermal.....	636
<i>epoprostenol sodium</i>	603	exforge.....	637
<i>eprosartan mesylate</i>	604	exforge hct.....	638
<i>eq nicotine transdermal</i>	605	exjade.....	639
erivedge.....	606	extavia subcutaneous kit.....	640
erleada.....	607	extina.....	641
ertaczo.....	608	eylea intravitreal.....	642
esbriet oral capsule.....	609	ez smart blood glucose test.....	643
esbriet oral tablet 267 mg.....	610	ez smart plus glucose test.....	644
esbriet oral tablet 801 mg.....	611	<i>ezetimibe</i>	645
<i>escitalopram oxalate oral tablet 10 mg</i>	612	<i>ezetimibe-simvastatin</i>	646
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	613	fabrazyme.....	647
<i>esomeprazole magnesium oral capsule delayed release 20 mg</i>	614	<i>famciclovir oral tablet 125 mg, 250 mg</i>	648
<i>esomeprazole magnesium oral capsule delayed release 40 mg</i>	615	<i>famciclovir oral tablet 500 mg</i>	649
<i>estradiol transdermal patch twice weekly</i>	616	fanapt.....	650
<i>estradiol transdermal patch weekly</i>	617	farxiga.....	651
<i>estradiol-norethindrone acet</i>	618	farydak.....	652
estrogel.....	619	faslodex intramuscular solution 250 mg/5ml.....	653
<i>eszopiclone</i>	620	fazaclo oral tablet dispersible 100 mg....	654
eucrisa.....	621	fazaclo oral tablet dispersible 12.5 mg....	655
euflexxa intra-articular solution prefilled syringe.....	622	fazaclo oral tablet dispersible 150 mg....	656
		fazaclo oral tablet dispersible 200 mg....	657
		fazaclo oral tablet dispersible 25 mg....	658
		feiba.....	659
		<i>felodipine er</i>	660
		femring.....	661
		<i>fenofibrate micronized</i>	665

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>fenofibrate oral capsule 150 mg, 50 mg</i>	662	<i>flurandrenolide external lotion</i>	703
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	663	<i>flurandrenolide external ointment</i>	702
<i>fenofibrate oral tablet 145 mg, 160 mg, 48</i>		<i>fluticasone-salmeterol</i>	704
<i>mg, 54 mg</i>	664	<i>fluvastatin sodium</i>	705
<i>fenofibric acid oral capsule delayed</i>		<i>fluvastatin sodium er</i>	706
<i>release</i>	666	<i>fluvoxamine maleate er</i>	709
<i>fenofibric acid oral tablet</i>	667	<i>fluvoxamine maleate oral tablet 100 mg..</i>	707
<i>fenoglide</i>	668	<i>fluvoxamine maleate oral tablet 25 mg, 50</i>	
<i>fentanyl</i>	669	<i>mg</i>	708
<i>fentanyl citrate buccal</i>	671	<i>focalin</i>	710
<i>fentora buccal tablet 100 mcg, 200 mcg,</i>		<i>focalin xr</i>	711
<i>400 mcg, 600 mcg, 800 mcg</i>	673	<i>follistim aq subcutaneous</i>	712
<i>ferriprox</i>	675	<i>fondaparinux sodium</i>	713
<i>fetzima</i>	676	<i>fora d10 2-in-1 monitor</i>	714
<i>fetzima titration</i>	677	<i>fora d15g 2-in-1 monitor</i>	715
<i>fibricor</i>	678	<i>fora d15g blood glucose test</i>	716
<i>fibryga</i>	679	<i>fora d20 2-in-1 monitor</i>	717
<i>fifty50 glucose test 2.0</i>	680	<i>fora d20 blood glucose test</i>	718
<i>finasteride oral tablet 5 mg</i>	681	<i>fora d40/g31 blood glucose</i>	719
<i>fioricet/codeine oral capsule 50-300-40-</i>		<i>fora g20 blood glucose test</i>	720
<i>30 mg</i>	682	<i>fora g30/prem v10 glucose test</i>	721
<i>fiorinal/codeine #3</i>	684	<i>fora gd20 test</i>	722
<i>firazyr</i>	686	<i>fora gd50 blood glucose test</i>	723
<i>firmagon</i>	687	<i>fora tn'g/tn'g voice</i>	724
<i>flebogamma dif</i>	688	<i>fora v10 blood glucose test</i>	725
<i>flector</i>	689	<i>fora v12 blood glucose test</i>	726
<i>flolan</i>	690	<i>fora v20 blood glucose test</i>	727
<i>flovent diskus</i>	691	<i>fora v30a blood glucose test</i>	728
<i>flovent hfa inhalation aerosol 110</i>		<i>foracare gd40 test</i>	729
<i>mcg/act, 44 mcg/act</i>	692	<i>foracare premium v10 test</i>	730
<i>flovent hfa inhalation aerosol 220</i>		<i>foracare test n go test</i>	731
<i>mcg/act</i>	693	<i>forfivo xl</i>	732
<i>fluocinonide external</i>	694	<i>fortamet oral tablet extended release 24</i>	
<i>fluoxetine hcl oral capsule 10 mg</i>	695	<i>hour 1000 mg</i>	733
<i>fluoxetine hcl oral capsule 20 mg</i>	696	<i>fortamet oral tablet extended release 24</i>	
<i>fluoxetine hcl oral capsule 40 mg</i>	697	<i>hour 500 mg</i>	735
<i>fluoxetine hcl oral capsule delayed release</i>		<i>forteio subcutaneous solution 600</i>	
.....	698	<i>mcg/2.4ml</i>	737
<i>fluoxetine hcl oral tablet 10 mg</i>	699	<i>fortesta</i>	738
<i>fluoxetine hcl oral tablet 20 mg</i>	700	<i>fortiscare test</i>	740
<i>fluoxetine hcl oral tablet 60 mg</i>	701	<i>fosamax oral tablet 70 mg</i>	741
<i>flurandrenolide external cream</i>	702	<i>fosamax plus d</i>	742

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

fragmin subcutaneous solution 10000 unit/ml, 12500 unit/0.5ml, 15000 unit/0.6ml, 18000 unit/0.72ml, 2500 unit/0.2ml, 5000 unit/0.2ml, 7500 unit/0.3ml, 95000 unit/3.8ml.....	743	<i>glatiramer acetate</i>	780
freestyle insulinx test.....	744	glatopa.....	781
freestyle lite test.....	745	gleevec oral tablet 100 mg.....	782
freestyle precision neo test.....	746	gleevec oral tablet 400 mg.....	783
freestyle test.....	747	gleostine oral capsule 10 mg, 100 mg, 40 mg.....	784
frova.....	748	glucagen diagnostic.....	786
<i>frovatriptan succinate</i>	749	glucagen hypokit.....	787
fulphila.....	750	glucagon emergency.....	788
fycompa oral tablet.....	751	gluco perfect 3 test.....	789
<i>gabapentin oral capsule</i>	752	glucocard 01 sensor plus.....	790
<i>gabapentin oral solution 250 mg/5ml</i>	753	glucocard expression test.....	791
<i>gabapentin oral tablet</i>	754	glucocard shine test.....	792
gabitril oral tablet 12 mg.....	755	glucocard vital test.....	793
gabitril oral tablet 16 mg.....	756	glucocard x-sensor.....	794
gabitril oral tablet 2 mg.....	757	glucocom test.....	795
gabitril oral tablet 4 mg.....	758	gluconavii blood glucose test.....	796
galafold.....	759	glumetza oral tablet extended release 24 hour 1000 mg.....	797
<i>galantamine hydrobromide</i>	760	glumetza oral tablet extended release 24 hour 500 mg.....	799
<i>galantamine hydrobromide er</i>	761	glyxambi.....	801
gammagard.....	762	gocovri.....	802
gammagard s/d less iga.....	763	gonal-f.....	803
gammaked.....	764	gonal-f rff.....	804
gammaplex intravenous solution 10 gm/200ml, 20 gm/400ml, 5 gm/100ml.....	765	gonal-f rff rediject.....	805
gamunex-c.....	766	gralise oral tablet 300 mg.....	806
<i>ganirelix acetate</i>	767	gralise oral tablet 600 mg.....	807
gattex.....	768	gralise starter.....	808
<i>ge100 blood glucose test</i>	769	granix.....	809
gel-one intra-articular prefilled syringe..	770	<i>guanfacine hcl er</i>	810
gelsyn-3.....	771	haegarda.....	811
genstrip 50.....	772	<i>halobetasol propionate</i>	812
genvisc 850.....	773	harvoni.....	813
genvoya.....	774	helixate fs.....	814
geodon oral.....	775	hemangeol.....	815
<i>ght test</i>	776	hemlibra.....	816
gilenya.....	777	hemofil m intravenous solution reconstituted 1000 unit, 1700 unit, 250 unit, 500 unit.....	817
gilotrif.....	778	hepsera.....	818
glassia.....	779	hetlioz.....	819

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

hizentra subcutaneous solution 1 gm/5ml, 10 gm/50ml, 2 gm/10ml, 4 gm/20ml.....	820	humira subcutaneous prefilled syringe kit 40 mg/0.4ml.....	829
<i>hm nicotine</i>	821	humira subcutaneous prefilled syringe kit 40 mg/0.8ml.....	830
<i>hm nicotine polacrilex mouth/throat lozenge 2 mg</i>	822	hyalgan.....	840
horizant oral tablet extended release 300 mg.....	823	hycamtin oral.....	841
horizant oral tablet extended release 600 mg.....	824	<i>hydrocod polst-cpm polst er oral suspension extended release</i>	842
hp acthar.....	825	<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	843
humate-p intravenous solution reconstituted 1000-2400 unit, 500-1200 unit.....	826	<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg</i>	845
humira pediatric crohns start subcutaneous prefilled syringe kit 40 mg/0.8ml.....	831	<i>hydrocodone-acetaminophen oral tablet 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	847
humira pediatric crohns start subcutaneous prefilled syringe kit 80 mg/0.8ml.....	832	<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	849
humira pediatric crohns start subcutaneous prefilled syringe kit 80 mg/0.8ml & 40mg/0.4ml.....	833	<i>hydromorphone hcl er</i>	861
humira pen subcutaneous pen-injector kit 40 mg/0.4ml.....	834	<i>hydromorphone hcl oral liquid</i>	851
humira pen subcutaneous pen-injector kit 40 mg/0.8ml.....	835	<i>hydromorphone hcl oral tablet 2 mg</i>	853
humira pen-cd/uc/hs starter subcutaneous pen-injector kit 40 mg/0.8ml.....	836	<i>hydromorphone hcl oral tablet 4 mg</i>	855
humira pen-cd/uc/hs starter subcutaneous pen-injector kit 80 mg/0.8ml.....	837	<i>hydromorphone hcl oral tablet 8 mg</i>	857
humira pen-ps/uv starter subcutaneous pen-injector kit 40 mg/0.8ml.....	838	<i>hydromorphone hcl rectal</i>	859
humira pen-ps/uv starter subcutaneous pen-injector kit 80 mg/0.8ml & 40mg/0.4ml.....	839	<i>hydroxyprogesterone caproate intramuscular oil</i>	863
humira subcutaneous prefilled syringe kit 10 mg/0.1ml, 20 mg/0.2ml.....	827	hymovis.....	864
humira subcutaneous prefilled syringe kit 10 mg/0.2ml, 20 mg/0.4ml.....	828	hyqvia.....	865
		hysingla er.....	866
		<i>ibandronate sodium oral</i>	868
		ibrance.....	869
		ibudone oral tablet 10-200 mg.....	870
		<i>ibudone oral tablet 5-200 mg</i>	870
		iclusig oral tablet 15 mg.....	872
		iclusig oral tablet 45 mg.....	873
		idelvion.....	874
		idhifa.....	875
		ilaris subcutaneous solution.....	876
		ilumya.....	877
		<i>imatinib mesylate oral tablet 100 mg</i>	878
		<i>imatinib mesylate oral tablet 400 mg</i>	879
		imbruvica oral capsule 70 mg.....	880

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

imbruvica oral tablet.....	881	isentress hd.....	918
<i>imiquimod external</i>	882	isentress oral tablet.....	916
imitrex nasal.....	883	isentress oral tablet chewable.....	917
imitrex oral.....	884	<i>isotretinoin oral</i>	919
imitrex statdose refill subcutaneous solution cartridge.....	886	<i>itraconazole oral capsule</i>	920
imitrex statdose system subcutaneous solution auto-injector.....	887	ixinity.....	921
imitrex subcutaneous.....	885	jadenu.....	922
impavido.....	888	jadenu sprinkle.....	923
impoyz.....	889	jakafi oral tablet 10 mg.....	924
in touch blood glucose test.....	890	jakafi oral tablet 15 mg, 20 mg, 25 mg, 5 mg.....	925
increlex.....	891	janumet.....	926
inderal xl oral capsule extended release 24 hour 80 mg.....	892	janumet xr oral tablet extended release 24 hour 100-1000 mg, 50-500 mg.....	927
<i>indomethacin oral</i>	893	janumet xr oral tablet extended release 24 hour 50-1000 mg.....	928
infinity blood glucose test.....	894	januvia.....	929
inflectra.....	895	jardiance.....	930
ingrezza oral capsule 40 mg.....	896	jentadueto.....	931
ingrezza oral capsule 80 mg.....	897	jentadueto xr oral tablet extended release 24 hour 2.5-1000 mg.....	932
inlyta.....	898	jentadueto xr oral tablet extended release 24 hour 5-1000 mg.....	933
innopran xl oral capsule extended release 24 hour 120 mg.....	899	jetrea intravitreal solution 0.375 mg/0.3ml.....	934
innopran xl oral capsule extended release 24 hour 80 mg.....	900	jevtana.....	935
intelence oral tablet 100 mg, 25 mg.....	901	jivi.....	936
intelence oral tablet 200 mg.....	902	jublia.....	937
intermezzo.....	903	juluca.....	938
intrarosa.....	904	juxtapid.....	939
intron a.....	905	jynarque.....	940
intuniv.....	906	kadian oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 200 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg.....	941
invega oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg.....	907	kalbitor.....	943
invega oral tablet extended release 24 hour 6 mg.....	908	kalydeco oral packet.....	944
invokamet.....	909	kalydeco oral tablet.....	945
invokamet xr.....	910	kanuma.....	946
invokana.....	911	kapvay oral tablet extended release 12 hour.....	947
<i>ipratropium bromide nasal</i>	912	kazano.....	948
<i>irbesartan</i>	913	kepivance.....	949
<i>irbesartan-hydrochlorothiazide</i>	914		
iressa.....	915		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

keppra xr oral tablet extended release 24 hour 500 mg.....	950	lamictal odt oral tablet dispersible 25 mg	984
keppra xr oral tablet extended release 24 hour 750 mg.....	951	lamictal odt oral tablet dispersible 50 mg	985
kerydin.....	952	lamictal xr oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg.....	986
<i>ketoconazole external foam</i>	953	lamictal xr oral tablet extended release 24 hour 200 mg.....	987
<i>ketoconazole oral</i>	954	lamictal xr oral tablet extended release 24 hour 250 mg, 300 mg.....	988
<i>ketorolac tromethamine oral</i>	955	<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg</i>	992
keveyis.....	956	<i>lamotrigine er oral tablet extended release 24 hour 200 mg</i>	993
kevzara.....	957	<i>lamotrigine er oral tablet extended release 24 hour 250 mg, 300 mg</i>	994
khedezla.....	958	<i>lamotrigine er oral tablet extended release 24 hour 50 mg</i>	995
kineret subcutaneous solution prefilled syringe.....	959	<i>lamotrigine oral tablet dispersible 100 mg, 200 mg</i>	989
kisqali 200 dose.....	960	<i>lamotrigine oral tablet dispersible 25 mg</i>	990
kisqali 400 dose.....	961	<i>lamotrigine oral tablet dispersible 50 mg</i>	991
kisqali 600 dose.....	962	<i>lansoprazole oral capsule delayed release 15 mg</i>	996
kisqali femara 200 dose.....	963	<i>lansoprazole oral capsule delayed release 30 mg</i>	997
kisqali femara 400 dose.....	964	<i>lansoprazole oral tablet dispersible</i>	998
kisqali femara 600 dose.....	965	latuda oral tablet 120 mg, 20 mg, 40 mg.....	999
kitabisk pak.....	966	latuda oral tablet 80 mg.....	1000
klofensaid ii.....	967	lazanda nasal solution 100 mcg/act, 400 mcg/act.....	1001
klor-con oral packet 20 meq.....	968	lazanda nasal solution 300 mcg/act.....	1003
koate.....	969	<i>leflunomide oral</i>	1005
koate-dvi.....	970	lemtrada.....	1006
kogenate fs.....	971	lenvima 10 mg daily dose.....	1007
kombiglyze xr oral tablet extended release 24 hour 2.5-1000 mg.....	972	lenvima 12 mg daily dose.....	1008
kombiglyze xr oral tablet extended release 24 hour 5-1000 mg, 5-500 mg.....	973	lenvima 14 mg daily dose.....	1009
korlym.....	974	lenvima 18 mg daily dose.....	1010
kovaltry.....	975	lenvima 20 mg daily dose.....	1011
kristalose.....	976	lenvima 24 mg daily dose.....	1012
<i>kroger blood glucose test</i>	977	lenvima 4 mg daily dose.....	1013
<i>kroger test</i>	978	lenvima 8 mg daily dose.....	1014
krystexxa.....	979		
kuvan.....	980		
kynamro subcutaneous solution prefilled syringe.....	981		
<i>lactulose oral packet</i>	982		
lamictal odt oral tablet dispersible 100 mg, 200 mg.....	983		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

lescol oral capsule 20 mg.....	1015	lovenox.....	1061
lescol xl.....	1016	lucemyra.....	1062
letairis.....	1017	lucentis intravitreal solution prefilled syringe.....	1063
leukine intravenous.....	1018	<i>luliconazole</i>	1064
<i>leuprolide acetate injection</i>	1019	lumigan ophthalmic solution 0.01 %....	1065
<i>levetiracetam er oral tablet extended release 24 hour 500 mg</i>	1020	lumizyme.....	1066
<i>levetiracetam er oral tablet extended release 24 hour 750 mg</i>	1021	lunesta.....	1067
<i>levorphanol tartrate oral</i>	1022	lupaneta pack.....	1068
levulan kerastick.....	1024	lupron depot (1-month).....	1069
lexapro oral tablet 10 mg.....	1025	lupron depot (3-month).....	1070
lexapro oral tablet 20 mg, 5 mg.....	1026	lupron depot (4-month).....	1071
lialda.....	1027	lupron depot (6-month).....	1072
liberty next generation test.....	1028	lupron depot-ped (1-month).....	1073
<i>liberty test</i>	1029	lupron depot-ped (3-month).....	1074
librax.....	1030	luzu.....	1075
<i>lidocaine external ointment</i>	1031	lynparza oral tablet.....	1076
<i>lidocaine external patch 5 %</i>	1033	lyrica cr oral tablet extended release 24 hour 165 mg, 82.5 mg.....	1077
<i>lidocaine pak</i>	1034	lyrica cr oral tablet extended release 24 hour 330 mg.....	1078
<i>lidocaine-prilocaine external cream</i>	1036	lysteda.....	1079
<i>lidocaine-tetracaine</i>	1038	macugen.....	1080
lidoderm.....	1039	makena intramuscular.....	1081
<i>linezolid oral suspension reconstituted</i> ...	1040	makena subcutaneous.....	1082
<i>linezolid oral tablet</i>	1041	<i>maprotiline hcl</i>	1083
linzess oral capsule 145 mcg, 290 mcg..	1042	marinol.....	1084
lipitor.....	1043	<i>matzim la oral tablet extended release 24 hour 180 mg, 300 mg, 360 mg</i>	1085
lipofen.....	1044	<i>matzim la oral tablet extended release 24 hour 240 mg</i>	1086
livalo.....	1045	mavyret.....	1087
lokelma.....	1046	maxalt oral tablet 10 mg.....	1088
lonhala magnair refill kit.....	1047	maxalt-mlt.....	1089
lonhala magnair starter kit.....	1048	<i>mefenamic acid oral</i>	1090
lonsurf oral tablet 15-6.14 mg.....	1049	<i>meijer blood glucose test</i>	1091
lonsurf oral tablet 20-8.19 mg.....	1050	meijer truetest test.....	1092
lorcet.....	1051	meijer truetrack test.....	1093
lorcet hd.....	1053	mekinist oral tablet 0.5 mg.....	1094
lorcet plus oral tablet 7.5-325 mg.....	1055	mekinist oral tablet 2 mg.....	1095
<i>losartan potassium oral tablet 25 mg, 50 mg</i>	1057	mektovi.....	1096
lotronex.....	1058	<i>memantine hcl er</i>	1097
<i>lovastatin</i>	1059		
lovaza.....	1060		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

menopur.....	1098	<i>methylphenidate hcl er oral tablet</i>	
menostar.....	1099	<i>extended release 10 mg.....</i>	1150
<i>mepredine hcl oral solution.....</i>	1100	<i>methylphenidate hcl er oral tablet</i>	
<i>mepredine hcl oral tablet 100 mg.....</i>	1102	<i>extended release 18 mg, 27 mg, 54 mg...</i>	1151
<i>mepredine hcl oral tablet 50 mg.....</i>	1104	<i>methylphenidate hcl er oral tablet</i>	
mephyton.....	1106	<i>extended release 20 mg.....</i>	1152
<i>mesalamine oral tablet delayed release 1.2</i>		<i>methylphenidate hcl er oral tablet</i>	
<i>gm.....</i>	1107	<i>extended release 24 hour 18 mg, 27 mg,</i>	
<i>mesalamine oral tablet delayed release</i>		<i>54 mg.....</i>	1155
<i>800 mg.....</i>	1108	<i>methylphenidate hcl er oral tablet</i>	
metadate er oral tablet extended release		<i>extended release 24 hour 36 mg.....</i>	1156
20 mg.....	1109	<i>methylphenidate hcl er oral tablet</i>	
<i>metformin hcl er (mod) oral tablet</i>		<i>extended release 36 mg.....</i>	1153
<i>extended release 24 hour 1000 mg.....</i>	1110	<i>methylphenidate hcl er oral tablet</i>	
<i>metformin hcl er (mod) oral tablet</i>		<i>extended release 72 mg.....</i>	1154
<i>extended release 24 hour 500 mg.....</i>	1112	<i>methylphenidate hcl oral solution 10</i>	
<i>metformin hcl er (osm) oral tablet</i>		<i>mg/5ml.....</i>	1146
<i>extended release 24 hour 1000 mg.....</i>	1114	<i>methylphenidate hcl oral solution 5</i>	
<i>metformin hcl er (osm) oral tablet</i>		<i>mg/5ml.....</i>	1147
<i>extended release 24 hour 500 mg.....</i>	1116	<i>methylphenidate hcl oral tablet.....</i>	1148
<i>methadone hcl intensol.....</i>	1133	<i>methylphenidate hcl oral tablet chewable</i>	
<i>methadone hcl oral concentrate.....</i>	1118	1149
<i>methadone hcl oral solution 10 mg/5ml..</i>	1121	<i>metoprolol succinate er oral tablet</i>	
<i>methadone hcl oral solution 5 mg/5ml....</i>	1124	<i>extended release 24 hour 100 mg, 50 mg</i>	1162
<i>methadone hcl oral tablet 10 mg.....</i>	1127	<i>metoprolol succinate er oral tablet</i>	
<i>methadone hcl oral tablet 5 mg.....</i>	1130	<i>extended release 24 hour 200 mg.....</i>	1163
methadose oral concentrate 10 mg/ml..	1136	<i>metoprolol succinate er oral tablet</i>	
methadose sugar-free.....	1139	<i>extended release 24 hour 25 mg.....</i>	1164
<i>methamphetamine hcl.....</i>	1142	<i>metoprolol-hctz er oral tablet extended</i>	
methergine oral.....	1143	<i>release 24 hour 100-12.5 mg.....</i>	1165
<i>methylin oral solution 10 mg/5ml.....</i>	1144	<i>metoprolol-hctz er oral tablet extended</i>	
<i>methylin oral solution 5 mg/5ml.....</i>	1145	<i>release 24 hour 25-12.5 mg, 50-12.5 mg.</i>	1166
<i>methylphenidate hcl er (cd).....</i>	1157	<i>mevacor oral tablet 40 mg.....</i>	1167
<i>methylphenidate hcl er (la) oral capsule</i>		<i>miacalcin injection.....</i>	1168
<i>extended release 24 hour 10 mg.....</i>	1158	<i>miacalcin nasal.....</i>	1169
<i>methylphenidate hcl er (la) oral capsule</i>		<i>micardis.....</i>	1170
<i>extended release 24 hour 20 mg, 40 mg..</i>	1159	<i>micardis hct.....</i>	1171
<i>methylphenidate hcl er (la) oral capsule</i>		<i>microdot test.....</i>	1172
<i>extended release 24 hour 30 mg.....</i>	1160	<i>miglustat.....</i>	1173
<i>methylphenidate hcl er (la) oral capsule</i>		<i>migranal.....</i>	1174
<i>extended release 24 hour 60 mg.....</i>	1161	<i>mimvey.....</i>	1175
		<i>minivelle.....</i>	1176

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

mirapex er.....	1177	<i>morphine sulfate rectal suppository 30 mg</i>	1205
mircera injection solution prefilled			
syringe.....	1178	movantik.....	1219
<i>mirtazapine oral</i>	1179	mozobil.....	1220
mirvaso.....	1180	ms contin oral tablet extended release	
mitigare.....	1181	100 mg, 200 mg, 60 mg.....	1221
<i>modafinil oral tablet 100 mg</i>	1182	ms contin oral tablet extended release 15	
<i>modafinil oral tablet 200 mg</i>	1184	mg, 30 mg.....	1223
monoclate-p intravenous kit 1000 unit.	1186	mulpleta.....	1225
mononine intravenous solution		multaq.....	1226
reconstituted 1000 unit.....	1187	<i>mupirocin calcium</i>	1228
monovisc.....	1188	<i>mupirocin external</i>	1227
<i>montelukast sodium oral packet</i>	1189	myalept.....	1229
<i>montelukast sodium oral tablet</i>	1190	mydayis.....	1230
<i>montelukast sodium oral tablet chewable</i>		myglucohealth test.....	1231
.....	1190	myobloc intramuscular solution 2500	
morphabond er.....	1191	unit/0.5ml, 5000 unit/ml.....	1232
<i>morphine sulfate (concentrate) oral</i>		<i>myorisan oral capsule 10 mg, 20 mg, 40</i>	
<i>solution 100 mg/5ml</i>	1207	<i>mg</i>	1233
<i>morphine sulfate (concentrate) oral</i>		myorisan oral capsule 30 mg.....	1233
<i>solution 20 mg/ml</i>	1209	myrbetriq.....	1234
<i>morphine sulfate er beads</i>	1217	mytesi.....	1235
<i>morphine sulfate er oral capsule extended</i>		<i>naftifine hcl external cream 2 %</i>	1236
<i>release 24 hour 10 mg, 100 mg, 20 mg, 30</i>		naftin external cream 2 %.....	1237
<i>mg, 50 mg, 60 mg, 80 mg</i>	1210	naftin external gel.....	1237
<i>morphine sulfate er oral capsule extended</i>		naglzyme.....	1238
<i>release 24 hour 40 mg</i>	1212	<i>nalocet</i>	1239
<i>morphine sulfate er oral tablet extended</i>		namenda oral tablet.....	1241
<i>release 100 mg, 200 mg, 60 mg</i>	1213	namenda titration pak.....	1242
<i>morphine sulfate er oral tablet extended</i>		namenda xr.....	1243
<i>release 15 mg, 30 mg</i>	1215	namenda xr titration pack.....	1244
<i>morphine sulfate oral solution 10 mg/5ml</i>		namzaric.....	1245
.....	1193	<i>naratriptan hcl</i>	1246
<i>morphine sulfate oral solution 20 mg/5ml</i>		narcana.....	1247
.....	1195	nasacort allergy 24hr.....	1248
<i>morphine sulfate oral tablet 15 mg</i>	1197	nasacort allergy 24hr children.....	1249
<i>morphine sulfate oral tablet 30 mg</i>	1199	<i>nasal allergy 24 hour</i>	1250
<i>morphine sulfate rectal suppository 10</i>		natesto.....	1251
<i>mg, 5 mg</i>	1201	natpara.....	1253
<i>morphine sulfate rectal suppository 20 mg</i>		nerlynx.....	1254
.....	1203	nesina oral tablet 12.5 mg, 6.25 mg.....	1255
		nesina oral tablet 25 mg.....	1256

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

neulasta subcutaneous solution prefilled syringe.....	1257	<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 34 mg, 40 mg, 8.5 mg</i>	1285
neupogen injection solution 300 mcg/ml, 480 mcg/1.6ml.....	1258	<i>nisoldipine er oral tablet extended release 24 hour 30 mg</i>	1286
neupogen injection solution prefilled syringe.....	1258	nityr.....	1287
neupro.....	1259	nivestym.....	1288
neurontin oral capsule.....	1260	nocurna.....	1289
neurontin oral tablet.....	1260	noctiva.....	1292
neutek 2tek glucose/pressure.....	1261	nolix external lotion.....	1293
neutek 2tek test.....	1262	norco oral tablet 10-325 mg.....	1294
<i>nevirapine er oral tablet extended release 24 hour 100 mg</i>	1263	norco oral tablet 5-325 mg, 7.5-325 mg	1295
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	1264	norditropin flexpro.....	1296
nexavar.....	1265	nothera oral capsule 100 mg.....	1297
nexium 24hr.....	1268	nothera oral capsule 200 mg, 300 mg..	1298
nexium oral capsule delayed release 40 mg.....	1266	nova max glucose test.....	1299
nexium oral packet.....	1267	<i>novarel intramuscular solution reconstituted 10000 unit</i>	1300
<i>next choice one dose</i>	1269	novoeight.....	1301
nicoderm cq.....	1270	novoseven rt.....	1302
<i>nicorelief mouth/throat gum</i>	1271	noxafil oral tablet delayed release.....	1303
nicorette mouth/throat gum.....	1272	nucala.....	1304
<i>nicotine step 1</i>	1274	nucynta er.....	1311
<i>nicotine step 2</i>	1275	nucynta oral tablet 100 mg.....	1305
<i>nicotine step 3</i>	1276	nucynta oral tablet 50 mg.....	1307
<i>nicotine transdermal patch 24 hour</i>	1273	nucynta oral tablet 75 mg.....	1309
nicotrol.....	1277	nuedexta.....	1313
nicotrol ns.....	1278	nuplazid oral capsule.....	1314
<i>nifedical xl oral tablet extended release 24 hour 60 mg</i>	1279	nuplazid oral tablet 10 mg.....	1315
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg</i>	1280	nuplazid oral tablet 17 mg.....	1316
<i>nifedipine er oral tablet extended release 24 hour 60 mg</i>	1281	nutropin aq nuspin 10.....	1317
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 90 mg</i> ..	1282	nutropin aq nuspin 20.....	1318
<i>nifedipine er osmotic release oral tablet extended release 24 hour 60 mg</i>	1283	nutropin aq nuspin 5.....	1319
ninlaro.....	1284	nuvigil.....	1320
		nuwiq.....	1322
		nymalize oral solution 60 mg/20ml.....	1323
		ocaliva oral tablet 5 mg.....	1324
		octagam.....	1325
		<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1326
		odefsey.....	1327

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

odomzo.....	1328	orencia subcutaneous solution prefilled syringe 125 mg/ml.....	1361
ofev.....	1329	orencia subcutaneous solution prefilled syringe 50 mg/0.4ml, 87.5 mg/0.7ml.....	1362
ofloxacin oral tablet 300 mg.....	1330	orenitram.....	1364
olanzapine oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg.....	1331	orfadin.....	1365
olanzapine oral tablet 2.5 mg.....	1332	orilissa oral tablet 150 mg.....	1366
olanzapine oral tablet dispersible 10 mg.....	1333	orilissa oral tablet 200 mg.....	1367
olanzapine oral tablet dispersible 15 mg, 20 mg, 5 mg.....	1331	orkambi oral packet.....	1368
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 6-25 mg, 6-50 mg.....	1334	orkambi oral tablet 100-125 mg.....	1369
olanzapine-fluoxetine hcl oral capsule 12-50 mg.....	1335	orkambi oral tablet 200-125 mg.....	1370
olmesartan medoxomil oral.....	1336	orthovisc intra-articular solution prefilled syringe.....	1371
olmesartan medoxomil-hctz.....	1337	oseltamivir phosphate oral capsule.....	1372
olmesartan-amlodipine-hctz.....	1338	oseltamivir phosphate oral suspension reconstituted.....	1373
olumiant.....	1339	oseni.....	1374
olux.....	1340	osmolex er.....	1375
olux-e.....	1341	otezla oral tablet.....	1376
omega-3-acid ethyl esters.....	1342	otezla oral tablet therapy pack.....	1377
omeprazole-sodium bicarbonate oral capsule.....	1343	ovidrel.....	1378
omeprazole-sodium bicarbonate oral packet.....	1344	oxaydo oral tablet abuse-deterrent 5 mg.....	1379
omnitrope.....	1345	oxaydo oral tablet abuse-deterrent 7.5 mg.....	1381
on call express blood glucose.....	1346	oxiconazole nitrate.....	1383
on call plus blood glucose.....	1347	oxistat.....	1384
on call vivid blood glucose.....	1348	oxtellar xr oral tablet extended release 24 hour 150 mg, 300 mg.....	1385
onetouch ultra blue.....	1349	oxtellar xr oral tablet extended release 24 hour 600 mg.....	1386
onetouch verio in vitro strip.....	1350	oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg..	1388
onfi oral tablet 10 mg, 20 mg.....	1351	oxybutynin chloride er oral tablet extended release 24 hour 5 mg.....	1389
onglyza.....	1352	oxybutynin chloride oral tablet.....	1387
onzetra xsail.....	1353	oxycodone hcl er oral tablet er 12 hour abuse-deterrent.....	1404
opana oral tablet 10 mg.....	1354	oxycodone hcl er oral tablet er 12 hour abuse-deterrent.....	1406
opana oral tablet 5 mg.....	1355	oxycodone hcl oral capsule.....	1390
opsumit.....	1356		
optumrx blood glucose test.....	1357		
oracea.....	1358		
oravig.....	1359		
orencia clickject.....	1363		
orencia intravenous.....	1360		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ
The formulary is updated the first week of each month.
12/01/2018

<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	1392	<i>paxil oral tablet 10 mg, 20 mg</i>	1440
<i>oxycodone hcl oral solution</i>	1394	<i>paxil oral tablet 30 mg, 40 mg</i>	1441
<i>oxycodone hcl oral tablet 10 mg, 5 mg</i> ...	1396	<i>pegasys proclick</i>	1444
<i>oxycodone hcl oral tablet 15 mg</i>	1398	<i>pegasys subcutaneous solution</i>	1443
<i>oxycodone hcl oral tablet 20 mg</i>	1400	<i>penlac</i>	1445
<i>oxycodone hcl oral tablet 30 mg</i>	1402	<i>pennsaid transdermal solution 2 %</i>	1446
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	1408	<i>pentasa oral capsule extended release 250 mg</i>	1447
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg</i>	1410	<i>pentasa oral capsule extended release 500 mg</i>	1448
<i>oxycodone-acetaminophen oral tablet 7.5-325 mg</i>	1412	<i>pentazocine-naloxone hcl</i>	1449
<i>oxycodone-aspirin oral tablet 4.8355-325 mg</i>	1414	<i>percocet oral tablet 10-325 mg</i>	1451
<i>oxycodone-ibuprofen</i>	1416	<i>percocet oral tablet 2.5-325 mg, 5-325 mg</i>	1452
<i>oxycontin oral tablet er 12 hour abuse-deterrent</i>	1418	<i>percocet oral tablet 7.5-325 mg</i>	1453
<i>oxymorphone hcl er</i>	1424	<i>perforomist</i>	1454
<i>oxymorphone hcl oral tablet 10 mg</i>	1420	<i>pexeva oral tablet 10 mg, 20 mg, 40 mg</i>	1455
<i>oxymorphone hcl oral tablet 5 mg</i>	1422	<i>pexeva oral tablet 30 mg</i>	1456
<i>oxytrol for women</i>	1426	<i>phenoxybenzamine hcl oral</i>	1457
<i>ozempic subcutaneous solution pen-injector 0.25 or 0.5 mg/dose</i>	1427	<i>phytonadione oral</i>	1458
<i>ozempic subcutaneous solution pen-injector 1 mg/dose</i>	1428	<i>picato external gel 0.015 %</i>	1459
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg</i>	1429	<i>picato external gel 0.05 %</i>	1460
<i>paliperidone er oral tablet extended release 24 hour 9 mg</i>	1430	<i>pioglitazone hcl</i>	1461
<i>palynziq</i>	1431	<i>pioglitazone hcl-glimepiride</i>	1462
<i>panzyga</i>	1432	<i>pioglitazone hcl-metformin hcl</i>	1463
<i>paricalcitol oral</i>	1433	<i>plavix</i>	1464
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 37.5 mg</i>	1436	<i>plegridy</i>	1465
<i>paroxetine hcl er oral tablet extended release 24 hour 25 mg</i>	1437	<i>plegridy starter pack</i>	1466
<i>paroxetine hcl oral tablet 10 mg, 20 mg</i>	1434	<i>plixda</i>	1467
<i>paroxetine hcl oral tablet 30 mg, 40 mg</i>	1435	<i>pocketchem ez test</i>	1468
<i>paroxetine mesylate</i>	1438	<i>pomalyst</i>	1469
<i>paxil cr</i>	1442	<i>ponstel</i>	1470
<i>paxil oral suspension</i>	1439	<i>potassium chloride oral packet</i>	1471
		<i>pradaxa</i>	1472
		<i>praluent subcutaneous solution pen-injector</i>	1473
		<i>pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg</i>	1474

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>pramipexole dihydrochloride er oral tablet extended release 24 hour 0.75 mg, 1.5 mg</i>	1475	procysbi oral capsule delayed release 75 mg.....	1510
<i>prasugrel hcl</i>	1476	prodigy no coding blood gluc.....	1511
pravachol oral tablet 20 mg, 40 mg, 80 mg.....	1477	profilnine.....	1512
<i>pravastatin sodium</i>	1478	profilnine sd.....	1513
precision pcx.....	1479	<i>progesterone micronized oral</i>	1514
precision pcx plus test.....	1480	prolastin-c intravenous solution.....	1515
precision point of care test.....	1481	prolastin-c intravenous solution reconstituted 1000 mg.....	1515
precision qid test.....	1482	prolia.....	1516
precision sof-tact test.....	1483	promacta oral tablet 12.5 mg, 25 mg, 50 mg.....	1517
precision xtra blood glucose.....	1484	promacta oral tablet 75 mg.....	1518
prefest.....	1485	prometrium.....	1519
<i>pregnyl</i>	1486	<i>propafenone hcl er</i>	1520
prevacid 24hr.....	1488	proscar.....	1521
prevacid oral capsule delayed release 30 mg.....	1487	protopic.....	1522
prevacid solutab.....	1489	provigil oral tablet 100 mg.....	1524
prevymis oral.....	1490	provigil oral tablet 200 mg.....	1526
prezista oral suspension.....	1491	prozac oral capsule 10 mg.....	1528
prezista oral tablet 150 mg, 600 mg, 75 mg.....	1492	prozac oral capsule 20 mg.....	1529
prezista oral tablet 800 mg.....	1493	prozac oral capsule 40 mg.....	1530
prilosec oral packet.....	1494	prudoxin.....	1531
primlev oral tablet 10-300 mg.....	1495	pts panels glucose test.....	1532
primlev oral tablet 5-300 mg.....	1497	pulmicort.....	1533
primlev oral tablet 7.5-300 mg.....	1499	pulmicort flexhaler.....	1534
pristiq oral tablet extended release 24 hour 100 mg, 50 mg.....	1501	pulmozyme.....	1535
pristiq oral tablet extended release 24 hour 25 mg.....	1502	purixan.....	1536
privigen.....	1503	qbrelis.....	1537
procardia xl oral tablet extended release 24 hour 30 mg, 90 mg.....	1504	qbrexza.....	1538
procardia xl oral tablet extended release 24 hour 60 mg.....	1505	qtern.....	1539
procentra.....	1506	qudexy xr oral capsule er 24 hour sprinkle 100 mg, 25 mg, 50 mg.....	1540
procrit.....	1507	qudexy xr oral capsule er 24 hour sprinkle 150 mg, 200 mg.....	1541
proctofoam hc.....	1508	<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	1546
procysbi oral capsule delayed release 25 mg.....	1509	<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg</i>	1547
		<i>quetiapine fumarate er oral tablet extended release 24 hour 400 mg, 50 mg</i>	1548

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>quetiapine fumarate oral tablet 100 mg, 50 mg</i>	1542	relistor subcutaneous solution 12 mg/0.6ml.....	1578
<i>quetiapine fumarate oral tablet 200 mg</i> ..	1543	relistor subcutaneous solution 8 mg/0.4ml.....	1579
<i>quetiapine fumarate oral tablet 25 mg</i> ...	1544	relpax.....	1580
<i>quetiapine fumarate oral tablet 300 mg, 400 mg</i>	1545	remeron oral tablet 15 mg, 30 mg.....	1581
quicktek test.....	1549	remeron soltab.....	1582
quillichew er oral tablet chewable extended release 20 mg, 40 mg.....	1550	remicade.....	1583
quillichew er oral tablet chewable extended release 30 mg.....	1551	remodulin.....	1584
quillivant xr.....	1552	renflexis.....	1585
quintet ac blood glucose test.....	1553	<i>repaglinide-metformin hcl</i>	1586
quintet blood glucose test.....	1554	repatha.....	1587
qvar redihaler.....	1555	repatha pushtronex system.....	1588
<i>ra nicotine transdermal</i>	1556	repatha sureclick.....	1589
ra truetest test.....	1557	requip xl oral tablet extended release 24 hour 12 mg.....	1590
<i>rabeprazole sodium</i>	1558	requip xl oral tablet extended release 24 hour 2 mg, 4 mg, 6 mg, 8 mg.....	1591
ranexa.....	1559	restoril oral capsule 22.5 mg, 7.5 mg....	1592
<i>rasagiline mesylate oral</i>	1560	retacrit.....	1593
ravicti.....	1561	retin-a.....	1594
rayaldee.....	1562	retin-a micro.....	1595
razadyne er.....	1564	retin-a micro pump.....	1596
razadyne oral tablet.....	1563	revatio intravenous.....	1597
rebetol oral solution.....	1565	revatio oral suspension reconstituted...	1597
rebif rebidose subcutaneous solution auto-injector.....	1567	revatio oral tablet.....	1598
rebif rebidose titration pack subcutaneous solution auto-injector....	1568	reveal blood glucose test.....	1599
rebif subcutaneous solution prefilled syringe.....	1566	revlimid.....	1600
rebif titration pack subcutaneous solution prefilled syringe.....	1569	rexulti.....	1601
rebinyn.....	1570	reyataz oral capsule 150 mg, 300 mg....	1602
recombinate.....	1571	reyataz oral capsule 200 mg.....	1603
rectiv.....	1572	rhofade.....	1604
refuah plus blood glucose test.....	1573	riastap.....	1605
regranex.....	1574	rightest gs100 blood glucose.....	1606
relenza diskhaler.....	1575	rightest gs300 blood glucose.....	1607
relexxii.....	1576	rightest gs550 blood glucose.....	1608
relistor oral.....	1577	rilutek.....	1609
		<i>riluzole</i>	1610
		<i>risedronate sodium oral tablet 150 mg</i> ..	1611
		<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	1612
		<i>risedronate sodium oral tablet 35 mg</i>	1613

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>risedronate sodium oral tablet delayed release</i>	1613	rubraca oral tablet 250 mg.....	1646
risperdal oral solution.....	1614	ruconest.....	1647
risperdal oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg.....	1615	rydapt.....	1648
risperdal oral tablet 4 mg.....	1616	rythmol sr.....	1649
risperidone m-tab oral tablet dispersible 0.5 mg, 1 mg, 2 mg.....	1620	ryvent.....	1650
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1617	sabril oral packet.....	1651
<i>risperidone oral tablet 3 mg</i>	1618	sabril oral tablet.....	1652
<i>risperidone oral tablet 4 mg</i>	1619	saizen.....	1653
<i>risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg</i>	1617	samsca oral tablet 15 mg.....	1654
<i>risperidone oral tablet dispersible 3 mg</i> ..	1618	samsca oral tablet 30 mg.....	1655
<i>risperidone oral tablet dispersible 4 mg</i> ..	1619	sancuso.....	1656
ritalin.....	1621	sandostatin injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml.....	1657
ritalin la oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg.....	1622	sandostatin lar depot.....	1658
ritalin la oral capsule extended release 24 hour 30 mg.....	1623	santyl.....	1659
rituxan intravenous solution.....	1624	saphris sublingual tablet sublingual 10 mg, 5 mg.....	1660
<i>rivastigmine</i>	1625	saphris sublingual tablet sublingual 2.5 mg.....	1661
<i>rivastigmine tartrate</i>	1626	savaysa.....	1662
rixubis.....	1627	savella.....	1663
<i>rizatriptan benzoate</i>	1628	savella titration pack.....	1664
<i>ropinirole hcl er oral tablet extended release 24 hour 12 mg</i>	1629	seebri neohaler.....	1665
<i>ropinirole hcl er oral tablet extended release 24 hour 2 mg, 4 mg, 6 mg, 8 mg</i> ..	1630	segluromet oral tablet 2.5-1000 mg.....	1666
<i>rosuvastatin calcium</i>	1631	segluromet oral tablet 2.5-500 mg.....	1667
roxycodone oral tablet 15 mg.....	1632	segluromet oral tablet 7.5-1000 mg, 7.5-500 mg.....	1668
roxycodone oral tablet 30 mg.....	1634	selzentry oral solution.....	1669
roxycodone oral tablet 5 mg.....	1636	selzentry oral tablet 150 mg, 75 mg.....	1670
roxybond oral tablet abuse-deterrent 15 mg.....	1638	selzentry oral tablet 25 mg.....	1671
roxybond oral tablet abuse-deterrent 30 mg.....	1640	sensipar.....	1672
roxybond oral tablet abuse-deterrent 5 mg.....	1642	serevent diskus.....	1673
rozerem.....	1644	seroquel oral tablet 100 mg, 50 mg.....	1674
rubraca oral tablet 200 mg, 300 mg.....	1645	seroquel oral tablet 200 mg.....	1675
		seroquel oral tablet 25 mg.....	1676
		seroquel oral tablet 300 mg, 400 mg.....	1677
		seroquel xr oral tablet extended release 24 hour 150 mg, 200 mg.....	1678
		seroquel xr oral tablet extended release 24 hour 300 mg, 400 mg.....	1679
		seroquel xr oral tablet extended release 24 hour 50 mg.....	1680

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

serostim subcutaneous solution		spiriva respimat inhalation aerosol	
reconstituted 4 mg, 5 mg, 6 mg.....	1681	solution 2.5 mcg/act.....	1713
<i>sertraline hcl oral tablet 100 mg</i>	1682	sporanox oral capsule.....	1714
<i>sertraline hcl oral tablet 25 mg</i>	1683	sporanox pulsepak.....	1715
<i>sertraline hcl oral tablet 50 mg</i>	1684	spritam.....	1716
signifor.....	1685	sprix.....	1717
signifor lar intramuscular suspension		sprycel oral tablet 100 mg, 140 mg.....	1718
reconstituted er.....	1686	sprycel oral tablet 20 mg, 50 mg, 70 mg,	
siklos.....	1687	80 mg.....	1719
<i>sildenafil citrate oral tablet 20 mg</i>	1688	steglatro oral tablet 15 mg.....	1720
silenor.....	1689	steglatro oral tablet 5 mg.....	1721
siliq.....	1690	steglujan.....	1722
simponi aria.....	1692	stelara intravenous.....	1723
simponi subcutaneous solution auto-		stelara subcutaneous solution 45	
injector.....	1691	mg/0.5ml.....	1724
simponi subcutaneous solution prefilled		stelara subcutaneous solution prefilled	
syringe.....	1691	syringe.....	1725
<i>simvastatin oral</i>	1693	stimate.....	1726
singulair oral packet.....	1694	stiolto respimat inhalation aerosol	
singulair oral tablet.....	1695	solution 2.5-2.5 mcg/act.....	1727
singulair oral tablet chewable.....	1695	stivarga.....	1728
sirturo.....	1696	strattera oral capsule 10 mg, 18 mg, 25	
sivextro oral.....	1697	mg, 40 mg, 60 mg.....	1729
<i>sm nicotine transdermal</i>	1698	strattera oral capsule 100 mg, 80 mg....	1730
smart sense value test.....	1699	strensiq.....	1731
smartest blood glucose test.....	1700	striant.....	1732
<i>sodium phenylbutyrate oral powder 3</i>		stribild.....	1734
<i>gm/ tsp</i>	1701	striverdi respimat.....	1735
<i>sodium phenylbutyrate oral tablet</i>	1701	suboxone sublingual film 12-3 mg.....	1736
<i>solia</i>	1702	suboxone sublingual film 2-0.5 mg, 4-1	
soliqua.....	1703	mg.....	1737
solosec.....	1704	suboxone sublingual film 8-2 mg.....	1738
solus v2 test.....	1705	subsys.....	1739
somatuline depot.....	1706	sular oral tablet extended release 24 hour	
somavert.....	1707	17 mg, 34 mg, 8.5 mg.....	1741
soriatane oral capsule 10 mg, 25 mg.....	1708	<i>sulfasalazine oral</i>	1742
sorilux.....	1709	<i>sulfazine</i>	1743
sovaldi.....	1710	<i>sumatriptan nasal</i>	1744
spiriva handihaler.....	1711	<i>sumatriptan succinate oral</i>	1745
spiriva respimat inhalation aerosol		<i>sumatriptan succinate refill subcutaneous</i>	
solution 1.25 mcg/act.....	1712	<i>solution cartridge</i>	1748

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	1746	syprine.....	1778
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml</i>	1747	taclonex external suspension.....	1779
<i>sumatriptan-naproxen sodium</i>	1749	<i>tacrolimus external</i>	1780
supartz fx.....	1750	<i>tadalafil (pah)</i>	1784
supprelin la.....	1751	<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1782
supreme test.....	1752	tafinlar.....	1785
sure edge test.....	1753	tagrisso.....	1786
surechek blood glucose test.....	1754	<i>take action</i>	1787
sure-test easyplus mini test.....	1755	takhzyro.....	1788
sutent oral capsule 12.5 mg.....	1756	taltz.....	1789
sutent oral capsule 25 mg.....	1757	talzenna oral capsule 0.25 mg.....	1790
sutent oral capsule 37.5 mg, 50 mg.....	1758	talzenna oral capsule 1 mg.....	1791
sylatron subcutaneous kit 200 mcg, 300 mcg, 600 mcg.....	1759	tamiflu oral capsule.....	1792
symbicort.....	1760	tamiflu oral suspension reconstituted 6 mg/ml.....	1793
symbyax oral capsule 12-25 mg, 12-50 mg, 6-25 mg, 6-50 mg.....	1761	taperdex 12-day.....	1794
symdeko.....	1762	taperdex 6-day.....	1795
symlinpen 120 subcutaneous solution pen-injector.....	1763	tarceva.....	1796
symlinpen 60 subcutaneous solution pen-injector.....	1765	targretin.....	1797
symproic.....	1766	tasigna oral capsule 150 mg, 200 mg....	1798
symtuza.....	1767	tasigna oral capsule 50 mg.....	1799
synagis.....	1768	tavalisse.....	1800
synarel.....	1769	<i>tazarotene external</i>	1801
syndros.....	1770	tazorac.....	1802
synera.....	1771	<i>tazia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg...</i>	1803
synjardy.....	1772	<i>tazia xt oral capsule extended release 24 hour 240 mg</i>	1804
synjardy xr oral tablet extended release 24 hour 10-1000 mg, 12.5-1000 mg, 5-1000 mg.....	1773	tecfidera.....	1805
synjardy xr oral tablet extended release 24 hour 25-1000 mg.....	1774	technivie.....	1806
synribo.....	1775	tekturna.....	1807
synvisc intra-articular solution prefilled syringe.....	1776	tekturna hct.....	1808
synvisc one intra-articular solution prefilled syringe.....	1777	telcare blood glucose test.....	1809
		<i>telmisartan</i>	1810
		<i>telmisartan-amlodipine</i>	1811
		<i>telmisartan-hctz</i>	1812
		<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	1813
		temodar oral.....	1814
		temovate external cream.....	1815
		temovate external ointment.....	1815
		<i>temozolomide</i>	1816

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

<i>tenofovir disoproxil fumarate</i>	1817	<i>toprol xl oral tablet extended release 24</i>	
<i>testim</i>	1818	<i>hour 200 mg</i>	1855
<i>testosterone transdermal gel 10 mg/lact</i>		<i>toprol xl oral tablet extended release 24</i>	
<i>(2%)</i>	1820	<i>hour 25 mg</i>	1856
<i>testosterone transdermal gel 12.5 mg/lact</i>		<i>toviaz</i>	1857
<i>(1%), 50 mg/5gm (1%)</i>	1822	<i>tracleer</i>	1858
<i>testosterone transdermal gel 20.25</i>		<i>tradjenta</i>	1859
<i>mg/1.25gm (1.62%), 20.25 mg/lact</i>		<i>tramadol hcl er (biphasic) oral tablet</i>	
<i>(1.62%), 40.5 mg/2.5gm (1.62%)</i>	1824	<i>extended release 24 hour 100 mg, 200 mg,</i>	
<i>testosterone transdermal gel 25 mg/2.5gm</i>		<i>300 mg</i>	1866
<i>(1%)</i>	1825	<i>tramadol hcl er oral capsule extended</i>	
<i>testosterone transdermal solution</i>	1827	<i>release 24 hour</i>	1862
<i>tetrabenazine oral tablet 12.5 mg</i>	1829	<i>tramadol hcl er oral tablet extended</i>	
<i>tetrabenazine oral tablet 25 mg</i>	1830	<i>release 24 hour</i>	1864
<i>tgt nicotine step one</i>	1831	<i>tramadol hcl oral</i>	1860
<i>tgt nicotine step three</i>	1832	<i>tramadol-acetaminophen</i>	1868
<i>tgt nicotine step two</i>	1833	<i>tranexamic acid oral</i>	1870
<i>thalomid</i>	1834	<i>trelegy ellipta</i>	1871
<i>thiola</i>	1835	<i>tristar mixject</i>	1872
<i>thrive mouth/throat gum 2 mg</i>	1836	<i>tremfya</i>	1873
<i>tiagabine hcl oral tablet 12 mg, 4 mg</i>	1837	<i>tretinoin external</i>	1874
<i>tiagabine hcl oral tablet 16 mg</i>	1838	<i>tretinoin microsphere</i>	1875
<i>tiagabine hcl oral tablet 2 mg</i>	1839	<i>tretinoin microsphere pump</i>	1876
<i>tiazac oral capsule extended release 24</i>		<i>tretten</i>	1877
<i>hour 120 mg, 180 mg, 300 mg, 360 mg,</i>		<i>treximet</i>	1878
<i>420 mg</i>	1840	<i>trezix oral capsule 320.5-30-16 mg</i>	1879
<i>tiazac oral capsule extended release 24</i>		<i>triamcinolone acetonide nasal aerosol</i>	1881
<i>hour 240 mg</i>	1841	<i>tribenzor</i>	1882
<i>tibsovo</i>	1842	<i>tricolor</i>	1883
<i>tiglutik</i>	1843	<i>trientine hcl</i>	1884
<i>tivicay oral tablet 10 mg, 25 mg</i>	1844	<i>triglide oral tablet 160 mg</i>	1885
<i>tivicay oral tablet 50 mg</i>	1845	<i>trilipix</i>	1886
<i>tivorbex</i>	1846	<i>trintellix</i>	1887
<i>tobi</i>	1847	<i>triptodur</i>	1888
<i>tobi podhaler</i>	1848	<i>triumeq</i>	1889
<i>tobramycin inhalation</i>	1849	<i>trivisc</i>	1890
<i>tolterodine tartrate er</i>	1850	<i>trokendi xr oral capsule extended release</i>	
<i>topamax sprinkle</i>	1851	<i>24 hour 100 mg, 25 mg, 50 mg</i>	1891
<i>topicort spray</i>	1852	<i>trokendi xr oral capsule extended release</i>	
<i>topiramate oral capsule sprinkle</i>	1853	<i>24 hour 200 mg</i>	1892
<i>toprol xl oral tablet extended release 24</i>		<i>trospium chloride</i>	1893
<i>hour 100 mg, 50 mg</i>	1854	<i>trospium chloride er</i>	1894

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

true metrix blood glucose test.....	1895	valcyte oral tablet.....	1931
truetest test.....	1896	<i>valganciclovir hcl oral solution</i>	
truetrack test.....	1897	<i>reconstituted.....</i>	1932
trulance.....	1898	<i>valganciclovir hcl oral tablet.....</i>	1933
trulicity.....	1899	<i>valsartan.....</i>	1934
tudorza pressair inhalation aerosol		<i>valsartan-hydrochlorothiazide.....</i>	1935
powder breath activated.....	1900	vanatol lq.....	1936
tussicaps oral capsule extended release		vanos.....	1937
12 hour 10-8 mg.....	1901	vantas.....	1938
tussionex pennkinetic er oral suspension		varubi oral.....	1939
extended release.....	1902	vascepa oral capsule 0.5 gm.....	1940
twynsta.....	1903	vascepa oral capsule 1 gm.....	1941
tybost.....	1904	vecamyl.....	1942
tykerb.....	1905	veletri.....	1943
tylenol with codeine #3.....	1906	veltassa.....	1944
tylenol with codeine #4.....	1907	vemlidy.....	1946
tymlos.....	1908	venclexta oral tablet 10 mg.....	1947
tysabri.....	1909	venclexta oral tablet 100 mg.....	1948
tyvaso.....	1910	venclexta oral tablet 50 mg.....	1949
tyvaso refill.....	1911	venclexta starting pack.....	1950
tyvaso starter.....	1912	<i>venlafaxine hcl er oral capsule extended</i>	
uceris oral.....	1913	<i>release 24 hour 150 mg.....</i>	1955
uceris rectal.....	1914	<i>venlafaxine hcl er oral capsule extended</i>	
ulesfia.....	1915	<i>release 24 hour 37.5 mg, 75 mg.....</i>	1956
uloric.....	1916	<i>venlafaxine hcl er oral tablet extended</i>	
ultima test.....	1917	<i>release 24 hour 150 mg.....</i>	1957
ultracet.....	1918	<i>venlafaxine hcl er oral tablet extended</i>	
ultram.....	1920	<i>release 24 hour 225 mg.....</i>	1958
ultratrak pro test.....	1921	<i>venlafaxine hcl er oral tablet extended</i>	
ultratrak ultimate test.....	1922	<i>release 24 hour 37.5 mg, 75 mg.....</i>	1959
ultravate external cream.....	1923	<i>venlafaxine hcl oral tablet 100 mg, 25 mg</i>	
ultravate external lotion.....	1924	1951
ultravate external ointment.....	1923	<i>venlafaxine hcl oral tablet 37.5 mg.....</i>	1952
unistrip1 generic.....	1925	<i>venlafaxine hcl oral tablet 50 mg.....</i>	1953
uptravi oral tablet 1000 mcg, 1200 mcg,		<i>venlafaxine hcl oral tablet 75 mg.....</i>	1954
1400 mcg, 1600 mcg, 400 mcg, 600 mcg,		ventavis.....	1960
800 mcg.....	1926	<i>verapamil hcl er oral capsule extended</i>	
uptravi oral tablet 200 mcg.....	1927	<i>release 24 hour 100 mg, 300 mg.....</i>	1961
uptravi oral tablet therapy pack.....	1927	<i>verapamil hcl er oral capsule extended</i>	
utibron neohaler.....	1928	<i>release 24 hour 200 mg.....</i>	1962
valchlor.....	1929	verdeso.....	1963
valcyte oral solution reconstituted.....	1930	verdrocet.....	1964

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

versacloz.....	1966	vytorin.....	2009
verzenio.....	1967	vyvanse oral capsule.....	2010
vesicare.....	1968	vyvanse oral tablet chewable.....	2011
viberzi.....	1969	vyzulta.....	2012
<i>vicodin es oral tablet 7.5-300 mg</i>	1972	wavesense presto.....	2013
<i>vicodin hp oral tablet 10-300 mg</i>	1974	wellbutrin sr.....	2014
<i>vicodin oral tablet 5-300 mg</i>	1970	wellbutrin xl.....	2015
victory agm-4000 test.....	1976	wilate intravenous kit.....	2016
victoza subcutaneous solution pen- injector.....	1977	xadago.....	2017
viekira pak.....	1978	xalatan.....	2018
viekira xr.....	1979	xalkori.....	2019
<i>vigabatrin</i>	1980	xanax xr.....	2020
vigadrone.....	1981	xarelto oral tablet 10 mg, 20 mg.....	2021
viibryd oral tablet.....	1982	xarelto oral tablet 15 mg.....	2022
vimizim.....	1983	xarelto oral tablet 2.5 mg.....	2023
vimovo.....	1984	xarelto starter pack.....	2024
vimpat oral solution.....	1985	xatmep.....	2025
vimpat oral tablet.....	1986	xeljanz.....	2026
viramune xr oral tablet extended release 24 hour 100 mg.....	1987	xeljanz xr.....	2027
viramune xr oral tablet extended release 24 hour 400 mg.....	1988	xeloda.....	2028
viread oral tablet.....	1989	xenazine oral tablet 12.5 mg.....	2029
vistogard.....	1990	xenazine oral tablet 25 mg.....	2030
visudyne.....	1991	xeomin.....	2031
vivelle-dot.....	1992	xepi.....	2032
vivlodex.....	1993	xermelo.....	2033
vizimpro.....	1994	xgeva.....	2034
vocal point blood glucose test.....	1995	xhance.....	2035
vogelxo pump.....	1998	xifaxan oral tablet 200 mg.....	2036
vogelxo transdermal gel 50 mg/5gm (1%)	1996	xifaxan oral tablet 550 mg.....	2037
voltaren transdermal.....	2000	xigduo xr oral tablet extended release 24 hour 2.5-1000 mg.....	2038
vonvendi.....	2001	xigduo xr oral tablet extended release 24 hour 5-1000 mg.....	2039
vosevi.....	2002	xodol oral tablet 5-300 mg, 7.5-300 mg	2040
votrient.....	2003	xolair.....	2041
vpriv.....	2004	xolegel.....	2042
vraylar oral capsule 1.5 mg.....	2005	xopenex hfa.....	2043
vraylar oral capsule 3 mg.....	2006	xtampza er.....	2044
vraylar oral capsule 4.5 mg, 6 mg.....	2007	xtandi.....	2046
vraylar oral capsule therapy pack.....	2008	xultophy.....	2047
		xuriden.....	2048

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018

xyntha intravenous kit 1000 unit, 2000 unit, 250 unit, 500 unit.....	2049	<i>zolpidem tartrate sublingual</i>	2086
xyntha solofuse.....	2050	zomig nasal solution 2.5 mg.....	2088
xyrem.....	2051	zomig nasal solution 5 mg.....	2089
yervoy.....	2052	zomig oral.....	2090
yonsa.....	2053	zomig zmt.....	2091
yosprala.....	2054	zonalon.....	2092
<i>zafirlukast</i>	2055	zontivity.....	2093
<i>zaleplon</i>	2056	zorbtive.....	2094
zarxio.....	2057	zorvolex.....	2095
zavesca.....	2058	ztlido.....	2096
zegerid oral capsule 40-1100 mg.....	2059	zubsolv sublingual tablet sublingual 0.7-0.18 mg.....	2097
zegerid oral packet.....	2060	zubsolv sublingual tablet sublingual 1.4-0.36 mg, 11.4-2.9 mg, 2.9-0.71 mg, 5.7-1.4 mg, 8.6-2.1 mg.....	2098
zegerid otc.....	2061	zurampic.....	2099
zejula.....	2062	zyban.....	2100
zelapar.....	2063	zyclara.....	2101
zelboraf.....	2064	zyclara pump external cream 2.5 %.....	2102
zemaira.....	2065	zyclara pump external cream 3.75 %.....	2103
zembrace symtouch.....	2066	zydelig.....	2104
zemplar oral capsule 1 mcg, 2 mcg.....	2067	zyflo.....	2105
<i>zenatane oral capsule 10 mg, 20 mg, 40 mg</i>	2068	zyflo cr.....	2106
zenatane oral capsule 30 mg.....	2068	zykadia.....	2107
zenzedi oral tablet 10 mg, 5 mg.....	2069	zypitamag.....	2108
zenzedi oral tablet 15 mg, 2.5 mg, 20 mg, 30 mg, 7.5 mg.....	2070	zyprexa oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg.....	2109
zepatier.....	2071	zyprexa oral tablet 2.5 mg.....	2110
zetia.....	2072	zyprexa zydis.....	2111
<i>zileuton er</i>	2073	zytiga oral tablet 250 mg.....	2112
zioptan.....	2074	zytiga oral tablet 500 mg.....	2113
<i>ziprasidone hcl</i>	2075	zyvox oral suspension reconstituted.....	2114
zocor.....	2076	zyvox oral tablet.....	2115
zohydro er oral capsule er 12 hour abuse-deterrent.....	2077		
zoladex.....	2079		
zolinza.....	2080		
<i>zolmitriptan oral</i>	2081		
zoloft oral tablet 100 mg.....	2082		
zoloft oral tablet 25 mg.....	2083		
zoloft oral tablet 50 mg.....	2084		
<i>zolpidem tartrate er</i>	2087		
<i>zolpidem tartrate oral</i>	2085		

2018 Aetna Pharmacy Drug Guide - Aetna Group Plan: NJ

The formulary is updated the first week of each month.

12/01/2018