Abilify

Products Affected

- ABILIFY ORAL TABLET

ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda. FOR ALL OTHER DIAGNOSIS: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone).
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
Other Criteria	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))
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	120 tablet Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Acamprosate Calcium

Products Affected

- *acamprosate calcium*

QL Criteria	6 tabs 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

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

PA Criteria	Criteria Details
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	150 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	

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

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	

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

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 formulary alternative proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 02/2017

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 formulary alternative proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 02/2017

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

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015

Acitretin

Products Affected

- *acitretin oral capsule 10 mg, 25 mg*

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

Acitretin

Products Affected

- *acitretin oral capsule 17.5 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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Actemra.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Actemra.html
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

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

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

PA Criteria	Criteria Details
Other Criteria	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))
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of two short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	120 lozenge Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Activella

Products Affected
- ACTIVELLA

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

Actonel

Products Affected

- ACTONEL ORAL TABLET 150 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
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: February 14, 2018

Actonel

Products Affected

- ACTONEL ORAL TABLET 30 MG, 5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	1 tab 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

Actonel

Products Affected

- ACTONEL ORAL TABLET 35 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	4 tablets Per 28 months
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actoplus Met

Products Affected
- ACTOPLUS MET

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

Actoplus met XR

Products Affected

- ACTOPLUS MET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 15-1000 MG

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

Actoplus met XR

Products Affected

- ACTOPLUS MET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 30-1000 MG

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

Actos

Products Affected
- ACTOS

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

Aczone

Products Affected
- ACZONE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo and generic dapsone gel
QL Criteria	60 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 06, 2017 Quantity Limits: August 25, 2015

Adalat CC

Products Affected

- ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 90 MG

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adderall

Products Affected
- ADDERALL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 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

Adderall XR

Products Affected
- ADDERALL XR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules 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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
QL Criteria	3 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advair Diskus

Products Affected
- ADVAIR DISKUS

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

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

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

Adynovate

Products Affected
- ADYNOVATE

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

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

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

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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: February 09, 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

Afeditab CR

Products Affected

- AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG

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

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/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	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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

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 characterzed 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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three (3) medications from the two (2) classes of medications FDA approved for migraine prophylaxis: seizure medications (topiramate, divalproex) and beta-blockers (propranolol, timolol).
QL Criteria	2 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: June 07, 2018 Quantity Limits: August 25, 2015

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 characterzed 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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three (3) medications from the two (2) classes of medications FDA approved for migraine prophylaxis: seizure medications (topiramate, divalproex) and beta-blockers (propranolol, timolol).
QL Criteria	2 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: June 07, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Breo, Dulera, Symbicort and propionate/salmeterol inhaler (generic Airduo)
QL Criteria	1 inhaler Per 30 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Breo, Dulera, Symbicort and propionate/salmeterol inhaler (generic Airduo)
QL Criteria	1 inhaler Per 30 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Breo, Dulera, Symbicort and propionate/salmeterol inhaler (generic Airduo)
QL Criteria	1 inhaler Per 30 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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 characterzed 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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three (3) medications from the two (2) classes of medications FDA approved for migraine prophylaxis: seizure medications (topiramate, divalproex) and beta-blockers (propranolol, timolol).
QL Criteria	1 injection Per 1 month
Notes/ References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: June 07, 2018 Quantity Limits: October 22, 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of a generic 5-HT3 receptor antagonist, such as granisetron or ondansetron, and one month of aprepitant
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

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

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

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

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

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/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	8 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 10 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

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: February 09, 2018

Alendronate Sodium

Products Affected

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

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

Alfuzosin HCl ER

Products Affected
- *alfuzosin hcl er*

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

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

Alinia

Products Affected
- ALINIA ORAL TABLET

QL Criteria	6 tablets Per 3 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alkeran

Products Affected
- ALKERAN ORAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of melphalan
Notes/ References	Annual Review: 07/2018
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

Alogliptin Benzoate

Products Affected
- *alogliptin benzoate*

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

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

Alogliptin-Pioglitazone

Products Affected

- *alogliptin-pioglitazone*

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

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each diphenoxylate/atropine and loperamide
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 30, 2017 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

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

Altoprev

Products Affected
- ALTOPREV

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

Alunbrig

Products Affected
- ALUNBRIG ORAL TABLET 180 MG

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: February 08, 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/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	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2018

Alunbrig

Products Affected

- ALUNBRIG ORAL TABLET 90 MG THERAPY PACK
- ALUNBRIG ORAL TABLET

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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and Qvar
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

Amabelz

Products Affected
- AMABELZ

QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: May 21, 2018

Ambien

Products Affected
- AMBIEN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 28, 2018 Quantity Limits: August 25, 2015

Ambien CR

Products Affected
- AMBIEN CR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 28, 2018 Quantity Limits: August 25, 2015

Amcinonide

Products Affected

- *amcinonide external cream*
- *amcinonide external lotion*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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

Amitiza

Products Affected
- AMITIZA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Linzess, Movantik, or Trulance.
QL Criteria	2 caps 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

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

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

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

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

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

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

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

Anoro Ellipta

Products Affected
- ANORO ELLIPTA

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

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	10 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ApexiCon E

Products Affected
- APEXICON E

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apriso

Products Affected
- APRISO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: January 30, 2018 Quantity Limits: August 25, 2015

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

Aptiom

Products Affected
- APTIOM ORAL TABLET 200 MG

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	6 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

Aptiom

Products Affected
- APTIOM ORAL TABLET 400 MG

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	3 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

Aptiom

Products Affected
- APTIOM ORAL TABLET 600 MG

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

Aptiom

Products Affected
- APTIOM ORAL TABLET 800 MG

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	1 tablet 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

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/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

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
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 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

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

Arava

Products Affected
- ARAVA

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

Arcalyst

Products Affected
- ARCALYST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Arcalyst.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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent
QL Criteria	1 cap Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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

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: June 14, 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

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

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

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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and Qvar
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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and Qvar
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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and Qvar
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

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

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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

Asacol HD

Products Affected
- ASACOL HD

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Delzicol, Lialda, or Pentasa
QL Criteria	6 tabs 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

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

PA Criteria	Criteria Details
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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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

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

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

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

Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG

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

Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 1 MG

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

Atacand

Products Affected
- ATACAND

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Atazanavir Sulfate

Products Affected

- *atazanavir sulfate oral capsule 150 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 08, 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

Atazanavir Sulfate

Products Affected

- *atazanavir sulfate oral capsule 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

Atelvia

Products Affected
- ATELVIA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	4 tabs 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

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

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

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

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

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

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 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Austedo.html
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

Avalide

Products Affected

- AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or valsartan/hctz
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 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

Avapro

Products Affected
- AVAPRO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

Avodart

Products Affected
- AVODART

ST Criteria	A documented contraindication, intolerance, allergy, or failure of dutasteride or finasteride
QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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: March 16, 2018

Azilect

Products Affected
- AZILECT

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

Azor

Products Affected
- AZOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand, Avapro, Cozaar, Micardis
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Azulfidine

Products Affected
- AZULFIDINE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	8 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: January 30, 2018 Quantity Limits: August 25, 2015

Azulfidine EN-tabs

Products Affected
- AZULFIDINE EN-TABS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	8 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: January 30, 2018 Quantity Limits: August 25, 2015

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

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: February 14, 2018

Banzel

Products Affected
- BANZEL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy and concomitant use of an anticonvulsant drug
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

Banzel

Products Affected
- BANZEL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy and concomitant use of an anticonvulsant drug
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	8 tabs 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

Baraclude

Products Affected
- BARACLUDE ORAL TABLET

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

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 - Value Plan
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

Beconase AQ

Products Affected
- BECONASE AQ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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 film Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Belsomra

Products Affected
- BELSOMRA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zolpidem er, or zaleplon
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 28, 2018 Quantity Limits: August 25, 2015

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

Benicar

Products Affected
- BENICAR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Benicar HCT

Products Affected
- BENICAR HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or valsartan/hctz
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/benlysta.html
Notes/ References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/benlysta.html
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

Benznidazole

Products Affected

- *benznidazole oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	Treatment of Chagas disease (American trypanosomiasis), caused by Trypanosoma cruzi 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: December 13, 2017

Benznidazole

Products Affected

- *benznidazole oral tablet 12.5 mg*

PA Criteria	Criteria Details
Covered Uses	Treatment of Chagas disease (American trypanosomiasis), caused by Trypanosoma cruzi 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: December 12, 2017

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Notes/ References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Betamethasone Valerate

Products Affected

- *betamethasone valerate external cream*
- *betamethasone valerate external lotion*
- *betamethasone valerate external ointment*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 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/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 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: February 14, 2018

Bethkis

Products Affected
- BETHKIS

QL Criteria	224 ml Per 1 fill
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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Anoro Ellipta and Stiolto
QL Criteria	1 inhaler Per 30 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of enoxaparin or dalteparin, or heparin
QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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/ANEOPL/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

Bicalutamide

Products Affected
- *bicalutamide*

QL Criteria	1 tab 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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 21, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Boniva

Products Affected
- BONIVA ORAL TABLET 150 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	1 tab Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
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

Bosulif

Products Affected
- BOSULIF 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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: January 10, 2018

Bosulif

Products Affected
- BOSULIF 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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/botulinum_toxin.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 06, 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 06, 2018

Breo Ellipta

Products Affected

- BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH

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

Breo Ellipta

Products Affected

- BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/INH

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

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

Brilinta

Products Affected

- BRILINTA ORAL TABLET 90 MG

QL Criteria	2 tabs 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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of paroxetine
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: March 19, 2018 Quantity Limits: August 25, 2015

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

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	60 vials (120ml) Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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 07, 2018

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	6 films 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

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 4.2-0.7 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 films 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

Bunavail

Products Affected
- BUNAVAIL BUCCAL FILM 6.3-1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	2 films 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

Buphenyl

Products Affected

- BUPHENYL ORAL POWDER 3 GM/TSP

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

Buphenyl

Products Affected
- 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	
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

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

PA Criteria	Criteria Details
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 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl sublingual tablet sublingual*

QL Criteria	3 tabs 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

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

QL Criteria	6 tabs 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

BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

QL Criteria	2 tabs 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 (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

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

PA Criteria	Criteria Details
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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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 bottles Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic beta-blockers
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic beta-blockers
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic beta-blockers and 2 generic angiotensin receptor blockers (ARBs)
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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/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	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Calcipotriene

Products Affected

- *calcipotriene external cream*
- *calcipotriene external ointment*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a medium to high potency topical steroid
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

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

Calcitrene

Products Affected
- *calcitrene*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a medium to high potency topical steroid
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/ANEOPL/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: December 12, 2017

Canasa

Products Affected
- CANASA

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

Candesartan Cilexetil

Products Affected

- *candesartan cilexetil*

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

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/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

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/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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Cardizem LA

Products Affected

- CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG, 360 MG

QL Criteria	1 tab Per 1 day
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 240 MG

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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: December 12, 2017

Casodex

Products Affected
- CASODEX

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

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

CeleBREX

Products Affected
- CELEBREX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two generic non steroidal anti-inflammatory drugs
QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

CeleXA

Products Affected
- CELEXA ORAL TABLET

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

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

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 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Cesamet

Products Affected
- CESAMET

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

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: February 14, 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

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	

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

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cimzia.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cimzia.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 year
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
QL Criteria	17 vials Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: September 01, 2018

Citalopram Hydrobromide

Products Affected

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

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

Claravis

Products Affected

- CLARAVIS ORAL CAPSULE 10 MG, 30 MG
- *claravis oral capsule 20 mg, 40 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

Clarinex

Products Affected
- CLARINEX ORAL TABLET

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

Clarinex-D 12 Hour

Products Affected
- CLARINEX-D 12 HOUR

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

Cleocin-T

Products Affected

- CLEOCIN-T EXTERNAL GEL
- CLEOCIN-T EXTERNAL LOTION
- CLEOCIN-T EXTERNAL SOLUTION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Climara Pro

Products Affected
- CLIMARA PRO

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

Clindagel

Products Affected
- CLINDAGEL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clindamycin Phosphate

Products Affected

- *clindamycin phosphate external gel*
- *clindamycin phosphate external lotion*
- *clindamycin phosphate external solution*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clobetasol Propionate

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Clobetasol Propionate

Products Affected

- *clobetasol propionate external foam*

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

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

Clobetasol Propionate

Products Affected

- *clobetasol propionate external lotion*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	236 ml Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Clobetasol Propionate

Products Affected

- *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

Clobetasol Propionate

Products Affected

- *clobetasol propionate external solution*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	100 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Clobetasol Propionate E

Products Affected

- *clobetasol propionate e*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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

Clobex

Products Affected
- CLOBEX EXTERNAL LOTION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	236 ml Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Clobex

Products Affected
- CLOBEX 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

Clobex Spray

Products Affected
- CLOBEX SPRAY

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

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

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

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate oral tablet 300 mg*

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

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate oral tablet 75 mg*

QL Criteria	1 tab 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 100 mg*
- *clozapine oral tablet dispersible 100 mg*

QL Criteria	9 tabs 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 tabs 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 25 mg, 50 mg*
- *clozapine oral tablet dispersible 25 mg*

QL Criteria	3 tabs 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 tab 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 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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	9 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	3 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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

PA Criteria	Criteria Details
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	24 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

Colazal

Products Affected
- COLAZAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	9 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: January 30, 2018 Quantity Limits: August 25, 2015

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

CombiPatch

Products Affected
- COMBIPATCH

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

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

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/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 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	3 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Complera

Products Affected
- COMPLERA

QL Criteria	1 tab Per 1 day
Notes/ References	
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 18 MG, 27 MG, 54 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

Concerta

Products Affected

- CONCERTA ORAL TABLET EXTENDED RELEASE 36 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 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

Copaxone

Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML

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

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

Cordran

Products Affected

- CORDRAN EXTERNAL CREAM 0.05 %

QL Criteria	4 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 14, 2018

Cordran

Products Affected
- 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: May 30, 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: March 16, 2018

Cordran

Products Affected
- CORDRAN EXTERNAL TAPE

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

Coreg CR

Products Affected
- COREG CR

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

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

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 nevibolol) 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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of a formulary ACE Inhibitor, ACE Inhibitor/HCTZ combination product, Angiotensin-Receptor Blocker, or Angiotensin-Receptor Blocker/HCTZ combination product
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 19, 2018 Quantity Limits: July 31, 2018

2018 Aetna Pharmacy Drug Guide - Value Plan
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cosentyx.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Cosentyx.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	63 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

Cozaar

Products Affected
- COZAAR ORAL TABLET 100 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Cozaar

Products Affected

- COZAAR ORAL TABLET 25 MG, 50 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	2 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Crestor

Products Affected
- CRESTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cycloset

Products Affected
- CYCLOSET

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

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 20 MG

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

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 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

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 60 MG

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

Cystadane

Products Affected
- CYSTADANE

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

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

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	4 bottles Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Daklinza.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: May 25, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Daklinza.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: May 25, 2018 Quantity Limits: August 25, 2015

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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Breo, Symbicort, Anoro, Stiolto, Incruse, or Spiriva
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: April 17, 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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Breo, Symbicort, Anoro, Stiolto, Incruse, or Spiriva
QL Criteria	1 tab 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

Dapsone

Products Affected
- *dapsone external*

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

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

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

Delzicol

Products Affected
- DELZICOL

QL Criteria	12 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Demser

Products Affected
- DEMSER

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/antihypertensive_misc.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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

Desonide

Products Affected
- *desonide external*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alclometasone cream/ointment
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

DesOwen

Products Affected

- DESOWEN EXTERNAL CREAM
- DESOWEN EXTERNAL LOTION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alclometasone cream/ointment
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Desoximetasone

Products Affected

- *desoximetasone external cream*
- *desoximetasone external gel*
- *desoximetasone external ointment*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tabs 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

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Detrol

Products Affected
- DETROL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Detrol LA

Products Affected
- DETROL LA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Dexedrine

Products Affected

- DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 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 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

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 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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

QL Criteria	4 tabs 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	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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: July 31, 2018

DiazePAM

Products Affected

- *diazepam rectal*

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

Dibenzyline

Products Affected
- DIBENZYLINE

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/antihypertensive_misc.html
QL Criteria	12 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 18, 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 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 01, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Differin

Products Affected

- DIFFERIN EXTERNAL GEL 0.3 %
- DIFFERIN EXTERNAL LOTION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dificid

Products Affected
- DIFICID

QL Criteria	20 tabs 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

Diflorasone Diacetate

Products Affected

- *diflorasone diacetate external cream*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Diflorasone Diacetate

Products Affected

- *diflorasone diacetate external ointment*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Dihydroergotamine Mesylate

Products Affected

- *dihydroergotamine mesylate nasal*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of two of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan
QL Criteria	8 ml Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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	22 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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	11 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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

Diltiazem HCl ER

Products Affected

- *diltiazem hcl er oral capsule extended release 24 hour 240 mg*

QL Criteria	2 cap 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 120 mg, 180 mg, 300 mg, 360 mg*

QL Criteria	1 cap 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 caps 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 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 tablet extended release 24 hour 180 mg, 300 mg, 360 mg*

QL Criteria	1 tab 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 tablet extended release 24 hour 240 mg*

QL Criteria	2 tab 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

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

Diovan

Products Affected
- DIOVAN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Diovan HCT

Products Affected
- DIOVAN HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or valsartan/hctz
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Dipentum

Products Affected
- DIPENTUM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: January 30, 2018 Quantity Limits: August 25, 2015

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

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

Ditropan XL

Products Affected

- DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Ditropan XL

Products Affected

- DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Divigel

Products Affected
- DIVIGEL

QL Criteria	1 packet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: October 02, 2018

Dolophine

Products Affected
- DOLOPHINE ORAL TABLET 10 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
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. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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

Dolophine

Products Affected
- DOLOPHINE ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
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. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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

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

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

Dovonex

Products Affected
- DOVONEX EXTERNAL CREAM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a medium to high potency topical steroid
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Doxercalciferol

Products Affected
- *doxercalciferol 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

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 caps 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

Duavee

Products Affected
- DUAVEE

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

Duetact

Products Affected
- DUETACT

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

Dulera

Products Affected
- DULERA

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

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 20 mg*

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

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 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

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 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: July 31, 2018

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 60 mg*

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/antiparkinsons.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of allopurinol or febuxostat
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: October 03, 2017 Step Therapy: October 04, 2017 Quantity Limits: August 25, 2015

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

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

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

Edarbi

Products Affected
- EDARBI

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Edarbyclor

Products Affected
- EDARBYCLOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or valsartan/hctz
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Edurant

Products Affected
- EDURANT

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

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: February 14, 2018

Effexor XR

Products Affected

- EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG, 75 MG

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

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 tab 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

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

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

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

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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition. Preferred topical corticosteroids include triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment.
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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: March 16, 2018

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: March 16, 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: March 12, 2018

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

Elocon

Products Affected

- ELOCON EXTERNAL CREAM
- ELOCON EXTERNAL OINTMENT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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

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	

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

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	

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

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

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 characterzed 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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three (3) medications from the two (2) classes of medications FDA approved for migraine prophylaxis: seizure medications (topiramate, divalproex) and beta-blockers (propranolol, timolol).
QL Criteria	1 injection Per 1 month
Notes/ References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: June 07, 2018 Quantity Limits: August 25, 2015

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

Emtriva

Products Affected
- EMTRIVA ORAL CAPSULE

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

Emverm

Products Affected
- EMVERM

QL Criteria	6 tablets Per 3 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enablex

Products Affected
- ENABLEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
QL Criteria	8 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 - Value Plan
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Enbrel.html
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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of hydroxyurea
QL Criteria	6 packets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: January 22, 2018 Quantity Limits: December 12, 2017

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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

Endocet

Products Affected

- ENDOCET 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	

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

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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

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

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

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Entyvio.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Epidiolex

Products Affected
- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletine 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/epidiolex.html
QL Criteria	20 ml Per 1 day
Notes/ References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: November 10, 2018 Quantity Limits: August 25, 2015

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

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

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

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

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

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

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

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/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	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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: March 13, 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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 20 mg, 5 mg*

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

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium*

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

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

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 oral tablet 0.5-0.1 mg*

QL Criteria	1 tab Per 1 day
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 oral tablet 1-0.5 mg*

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

Estrogel

Products Affected
- ESTROGEL

QL Criteria	50 grams Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eszopiclone

Products Affected
- *eszopiclone*

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

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

Evamist

Products Affected
- EVAMIST

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	120 tabs 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

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

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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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

Exforge

Products Affected
- EXFORGE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand, Avapro, Cozaar, Micardis
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Exforge HCT

Products Affected
- EXFORGE HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand HCT, Avalide, Hyzaar, Micardis HCT
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 27, 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

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

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/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

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

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

Fabior

Products Affected
- FABIOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Famciclovir

Products Affected
- *famciclovir oral*

QL Criteria	21 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fanapt

Products Affected
- FANAPT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Fanapt Titration Pack

Products Affected
- FANAPT TITRATION PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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: November 15, 2017

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/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	12 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

FazaClo

Products Affected

- FAZACLO 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	9 tabs 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

FazaClo

Products Affected

- FAZACLO 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	1 tab 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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	6 tabs 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

FazaClo

Products Affected

- FAZACLO 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	4 tabs 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

FazaClo

Products Affected

- FAZACLO 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	3 tabs 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

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

Felodipine ER

Products Affected
- *felodipine er*

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

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

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

Fenofibrate

Products Affected

- *fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg*

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

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

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

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

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

PA Criteria	Criteria Details
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 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

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

PA Criteria	Criteria Details
Other Criteria	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))
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of two short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	120 lozenge Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
Other Criteria	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))
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	120 tablets Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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/Antidotes.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

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 cap Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 cap Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Fibricor

Products Affected
- FIBRICOR

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

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/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

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

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	

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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
QL Criteria	3 syringes Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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

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

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

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: March 15, 2018

Fluocinolone Acetonide

Products Affected

- *fluocinolone acetonide external cream*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alclometasone cream/ointment
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Fluocinolone Acetonide

Products Affected

- *fluocinolone acetonide external ointment*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Fluocinonide

Products Affected

- *fluocinonide external cream*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Fluocinonide

Products Affected

- *fluocinonide external cream*
- *fluocinonide external gel*
- *fluocinonide external ointment*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Fluocinonide

Products Affected

- *fluocinonide external solution*

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

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: July 31, 2018

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: July 31, 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: July 31, 2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

QL Criteria	4 caps Per 1 month
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 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: July 31, 2018

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

QL Criteria	4 tabs 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 tablet 60 mg*

QL Criteria	1 tab Per 1 Day
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

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: May 14, 2018

Fluticasone Propionate

Products Affected

- *fluticasone propionate external cream*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 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

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

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: July 31, 2018

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

FluvoxaMINE Maleate ER

Products Affected

- *fluvoxamine maleate er*

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

Focalin

Products Affected
- FOCALIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 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

Focalin XR

Products Affected
- FOCALIN XR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules 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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Fosamax Plus D

Products Affected
- FOSAMAX PLUS D

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	4 tabs 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

Fragmin

Products Affected

- FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/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

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

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

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

Frova

Products Affected
- FROVA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of three of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan
QL Criteria	9 tablets Per 30 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Fuzeon

Products Affected

- FUZEON 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/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

Fycompa

Products Affected
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizures, generalized tonic-clonic seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures or generalized tonic-clonic seizures, and documented use as adjunct therapy with one or more other FDA approved Anti-Epileptic Drug (AED).
Age Restrictions	12 years and greater
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tab 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

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gabapentin

Products Affected

- *gabapentin oral tablet*

QL Criteria	6 tabs 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 12 MG, 4 MG

QL Criteria	4 tabs 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 16 MG

QL Criteria	3 tabs 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 2 MG

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

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: September 19, 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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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 box Per 30 fillss
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gelnique

Products Affected

- GELNIQUE TRANSDERMAL GEL 10 %

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

Genotropin

Products Affected
- GENOTROPIN

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Genotropin MiniQuick

Products Affected
- GENOTROPIN MINIQUICK

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	2 caps Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

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

Gilenya

Products Affected
- GILENYA 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/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

Gilenya

Products Affected
- GILENYA ORAL CAPSULE 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/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 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glassia

Products Affected
- GLASSIA

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

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

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

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	

Revision Date	Prior Authorization: April 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GlucaGen HypoKit

Products Affected
- GLUCAGEN HYPOKIT

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

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: July 31, 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: November 15, 2017

Gralise

Products Affected
- GRALISE ORAL TABLET 300 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of gabapentin
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

Gralise

Products Affected
- GRALISE ORAL TABLET 600 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of gabapentin
QL Criteria	3 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

Gralise Starter

Products Affected
- GRALISE STARTER

ST Criteria	A documented contraindication, intolerance, allergy, or failure of gabapentin
QL Criteria	1 pack Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: April 24, 2018 Quantity Limits: August 25, 2015

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
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

Halobetasol Propionate

Products Affected

- *halobetasol propionate*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	50 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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

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

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

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

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

Hepsera

Products Affected
- HEPSERA

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

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	
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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.
ST Criteria	FOR POST-HERPETIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of one month of gabapentin. FOR RESTLESS LEG SYNDROME:A documented contraindication, intolerance, allergy, or failure of one month of pramipexole, or ropinirole.
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	FOR POST-HERPETIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of one month of gabapentin. FOR RESTLESS LEG SYNDROME:A documented contraindication, intolerance, allergy, or failure of one month of pramipexole, or ropinirole.
QL Criteria	1 tablet Per 2 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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

Humatrope

Products Affected
- HUMATROPE

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
QL Criteria	2 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
QL Criteria	6 inections 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 - Value Plan
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
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 - Value Plan
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
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 - Value Plan
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
QL Criteria	6 inections 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 - Value Plan
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Humira.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

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/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

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

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 - Value Plan
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

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	

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

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	

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

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	

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

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

PA Criteria	Criteria Details
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	22 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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	11 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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 suppositories Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

Hyzaar

Products Affected
- HYZAAR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or valsartan/hctz
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Ibandronate Sodium

Products Affected
- *ibandronate sodium oral*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	1 tab Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	21 capsules Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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/Idhifa.html
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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Ilumya.html
QL Criteria	1 syringe Per 84 Days
Notes/ References	
Revision Date	Prior Authorization: September 05, 2018 Step Therapy: September 10, 2018 Quantity Limits: September 30, 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/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	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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

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/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	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: April 17, 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

Imiquimod Pump

Products Affected
- *imiquimod pump*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic Aldara
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 22, 2018 Quantity Limits: August 25, 2015

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: July 17, 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: July 17, 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: July 17, 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: July 17, 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: July 31, 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 Leishmania donovani, Cutaneous leishmaniasis due to Leishmania braziliensis, Leishmania guyanensis, and Leishmania panamensis, or Mucosal leishmaniasis due to Leishmania braziliensis
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	28 days
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 16, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imvexxy Maintenance Pack

Products Affected
- IMVEXXY MAINTENANCE PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of an estrogen product such as estradiol, estropipate, or conjugated estrogens
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 03, 2018 Quantity Limits: August 25, 2015

Imvexxy Starter Pack

Products Affected
- IMVEXXY STARTER PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of an estrogen product such as estradiol, estropipate, or conjugated estrogens
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 03, 2018 Quantity Limits: August 25, 2015

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

Incruse Ellipta

Products Affected
- INCRUSE ELLIPTA

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

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Inflectra.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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: March 16, 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

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/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	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

InnoPran XL

Products Affected

- INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG

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

Intelence

Products Affected

- INTELENCE ORAL TABLET 100 MG, 25 MG

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

Intelence

Products Affected

- INTELENCE ORAL TABLET 200 MG

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

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

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: clonidine/sr, guanfacine, amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine, or Vyvanse
QL Criteria	1 tab 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

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 1.5 MG, 3 MG, 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Invokamet

Products Affected
- INVOKAMET

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

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

Invokana

Products Affected
- INVOKANA

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

Ipratropium Bromide

Products Affected
- *ipratropium bromide nasal*

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

Irbesartan

Products Affected
- *irbesartan*

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

Irbesartan-Hydrochlorothiazide

Products Affected
- *irbesartan-hydrochlorothiazide*

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

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/ANEOPL/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

Isentress

Products Affected
- ISENTRESS ORAL TABLET

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

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

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

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

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

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

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/Antidotes.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

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

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/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

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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet

Products Affected
- JANUMET

QL Criteria	2 tabs 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 100-1000 MG, 50-500 MG

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

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

Jardiance

Products Affected
- JARDIANCE

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

Jentadueto

Products Affected
- JENTADUETO

QL Criteria	2 tabs 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

Jentadueto XR

Products Affected

- JENTADUETO 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

Jentadueto XR

Products Affected

- JENTADUETO 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

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

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)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one systemic (oral) alternative such as terbinafine, itraconazole, or griseofulvin
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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

Juluca

Products Affected
- JULUCA

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ID/antiviral_hiv.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 22, 2018 Quantity Limits: January 10, 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Antilipidemic Agents_HOFH.html
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: November 28, 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

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	

PA Criteria	Criteria Details
Prescriber Restrictions	
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/hereditary_angioedema.html
Notes/ References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tabs 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

Karbinal ER

Products Affected

- KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of carbinoxamine and one week of an over the counter Claritin, Zyrtec, or Allegra
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 19, 2018 Quantity Limits: August 25, 2015

Kcentra

Products Affected
- KCENTRA

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

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG

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

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 750 MG

QL Criteria	4 tabs 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)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one systemic (oral) alternative such as terbinafine, itraconazole, or griseofulvin
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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

Ketoconazole

Products Affected
- *ketoconazole oral*

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

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: April 16, 2018

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/carbonic_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

Kevzara

Products Affected
- KEVZARA

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Kevzara.html
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

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Kineret.html
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

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/ANEOPL/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

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/ANEOPL/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

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/ANEOPL/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

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/ANEOPL/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

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/ANEOPL/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

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/ANEOPL/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

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

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

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

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

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/antidiabetic 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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/gout.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Antilipidemic Agents_HOFH.html
QL Criteria	4 syringe Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	2 tabs 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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 200 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	2 tabs 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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 25 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	6 tabs 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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 50 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	3 tabs 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

LaMICtal XR

Products Affected
- LAMICTAL XR ORAL KIT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
Notes/ References	Annual Review: 07/2018
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 100 MG, 25 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	1 tab 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

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 200 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	3 tabs 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

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	2 tabs 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

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 100 mg, 200 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
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

LamoTRIgine ER

Products Affected

- *lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	1 tab 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

LamoTRIgine ER

Products Affected

- *lamotrigine er oral tablet extended release 24 hour 200 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	3 tabs 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

LamoTRIgine ER

Products Affected

- *lamotrigine er oral tablet extended release 24 hour 250 mg, 300 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
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

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: July 31, 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: April 17, 2018

Latuda

Products Affected

- LATUDA ORAL TABLET 120 MG, 40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
QL Criteria	1 tab 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

Latuda

Products Affected

- LATUDA ORAL TABLET 20 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
QL Criteria	1 tab 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

Latuda

Products Affected
- LATUDA ORAL TABLET 60 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
Notes/ References	Annual Review: 07/2018
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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
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

Leflunomide

Products Affected
- *leflunomide oral*

QL Criteria	1 tab 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	5 vials Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	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

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/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	3 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: September 19, 2018

2018 Aetna Pharmacy Drug Guide - Value Plan
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/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	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

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/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	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

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/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	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

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/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	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

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/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	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: September 19, 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/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	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

Lescol

Products Affected
- LESCOL ORAL CAPSULE 20 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

Lescol XL

Products Affected
- LESCOL XL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

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

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

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

LevETIRAcetam ER

Products Affected

- *levetiracetam er oral tablet extended release 24 hour 500 mg*

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

LevETIRAcetam ER

Products Affected

- *levetiracetam er oral tablet extended release 24 hour 750 mg*

QL Criteria	4 tabs 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

PA Criteria	Criteria Details
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
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Lialda

Products Affected
- LIALDA

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

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), of 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

PA Criteria	Criteria Details
Other Criteria	*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
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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic gabapentin or Lyrica
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

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), of 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

PA Criteria	Criteria Details
Other Criteria	*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
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

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

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

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic gabapentin or Lyrica
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

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

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

Lipitor

Products Affected
- LIPITOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

Lipofen

Products Affected
- LIPOFEN

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

Livalo

Products Affected
- LIVALO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 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 - Value Plan
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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of either Spiriva or Incruse Ellipta (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	1 kit Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of either Spiriva or Incruse Ellipta (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	1 kit Per 1 year
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

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/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	100 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	80 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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	

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

Lortab

Products Affected

- LORTAB ORAL ELIXIR 10-300 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	

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	135 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each diphenoxylate/atropine and loperamide
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 30, 2017 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Lovastatin

Products Affected
- *lovastatin*

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

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

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/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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 21, 2018 Quantity Limits: August 25, 2015

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

Lunesta

Products Affected
- LUNESTA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 28, 2018 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

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

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

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

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

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

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

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/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	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Lysteda

Products Affected
- LYSTEDA

QL Criteria	30 tabs 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/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

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: August 25, 2015

Maprotiline HCl

Products Affected

- *maprotiline 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

Maprotiline HCl

Products Affected

- *maprotiline hcl oral tablet 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

Maprotiline HCl

Products Affected

- *maprotiline hcl oral tablet 75 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

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 caps 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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 180 MG, 300 MG, 360 MG

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Mavyret.html
QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: May 25, 2018 Quantity Limits: August 25, 2015

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 11, 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: August 25, 2015

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: March 16, 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/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	3 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 06, 2018

Memantine HCl

Products Affected
- *memantine hcl 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

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

Menostar

Products Affected
- MENOSTAR

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

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

PA Criteria	Criteria Details
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	90 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: December 27, 2017

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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	18 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Metadate ER

Products Affected

- METADATE ER ORAL TABLET EXTENDED RELEASE 20 MG

QL Criteria	3 tabs 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

Methadone HCl

Products Affected
- *methadone hcl oral concentrate*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
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. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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

PA Criteria	Criteria Details
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	15 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadone HCl

Products Affected
- *methadone hcl oral solution 5 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
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. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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	30 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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

Methadone HCl

Products Affected
- *methadone hcl oral tablet 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
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. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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

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	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadose

Products Affected

- METHADOSE ORAL CONCENTRATE 10 MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
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. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
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 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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

PA Criteria	Criteria Details
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 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 tabs 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

Methergine

Products Affected
- METHERGINE ORAL

QL Criteria	28 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	30 ML 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

Methylin

Products Affected

- METHYLIN ORAL SOLUTION 5 MG/5ML

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	60 ML 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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral solution 10 mg/5ml*

QL Criteria	30 ML 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

Products Affected

- *methylphenidate hcl oral solution 5 mg/5ml*

QL Criteria	60 ML 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

Products Affected

- *methylphenidate hcl oral tablet*

QL Criteria	6 tablets 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

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: September 11, 2018

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

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

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: February 08, 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

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

QL Criteria	1 cap 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 (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

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 40 mg*

QL Criteria	1 cap 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: February 14, 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 tabs 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 200 mg*

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

Mevacor

Products Affected
- MEVACOR ORAL TABLET 40 MG

QL Criteria	2 tabs 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 NASAL

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
QL Criteria	1 bottle Per 1 fill
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Micardis

Products Affected
- MICARDIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Micardis HCT

Products Affected
- MICARDIS HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two of the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or valsartan/hctz
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

Mimvey

Products Affected
- MIMVEY

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

Mimvey Lo

Products Affected
- MIMVEY LO

QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: May 21, 2018

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

Mirapex ER

Products Affected
- MIRAPEX ER

QL Criteria	1 tab 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

Mirtazapine

Products Affected

- *mirtazapine 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

Mirtazapine

Products Affected

- *mirtazapine oral tablet dispersible*

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

Mitigare

Products Affected
- MITIGARE

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

Modafinil

Products Affected
- *modafinil*

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

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 tabs 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

Mometasone Furoate

Products Affected

- *mometasone furoate external cream*
- *mometasone furoate external ointment*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Monoclate-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

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

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

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

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: July 16, 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

PA Criteria	Criteria Details
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	45 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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	22.5 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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	

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 suppositories Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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 suppositories Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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 suppositories Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	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	

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

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	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	

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

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

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	

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

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	

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

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

PA Criteria	Criteria Details
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

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: July 31, 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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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/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	1 /day for 7 days Per 30 days
Notes/ References	
Revision Date	Prior Authorization: June 27, 2018 Step Therapy: August 25, 2015 Quantity Limits: September 19, 2018

Multaq

Products Affected
- MULTAQ

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

Mupirocin

Products Affected

- *mupirocin external*

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

Mupirocin Calcium

Products Affected

- *mupirocin calcium*

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

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	15 vials Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

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

Myrbetriq

Products Affected

- MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Myrbetriq

Products Affected

- MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 50 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin)
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of at least one anti-motility agent (loperamide, diphenoxylate/atropine, bismuth subsalicylate)
QL Criteria	2 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

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

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

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

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

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

Namzaric

Products Affected
- NAMZARIC

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

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

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: June 19, 2018

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: July 31, 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

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

Nasonex

Products Affected
- NASONEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 cartridges Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Neupogen

Products Affected

- NEUPOGEN INJECTION SOLUTION
  300 MCG/ML, 480 MCG/1.6ML

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/G-CSF.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: April 24, 2018 Quantity Limits: August 25, 2015

Neupogen

Products Affected

- 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

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

QL Criteria	6 caps 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 TABLET

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

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/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	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexIUM

Products Affected

- NEXIUM ORAL CAPSULE DELAYED RELEASE 40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 formulary alternative proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015

NexIUM

Products Affected
- NEXIUM ORAL PACKET

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 formulary alternative proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 packet Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 06, 2017 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

Nicotine

Products Affected
- *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

Nicotine Polacrilex

Products Affected

- *nicotine polacrilex mouth/throat gum*

QL Criteria	24 pieces Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotine Polacrilex

Products Affected

- *nicotine polacrilex mouth/throat lozenge*

QL Criteria	20 pieces Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotrol

Products Affected
- NICOTROL

QL Criteria	16 cartridges Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotrol NS

Products Affected
- NICOTROL NS

QL Criteria	12 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG

QL Criteria	2 tabs 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 tab 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 60 mg*

QL Criteria	2 tabs 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 tab 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 60 mg*

QL Criteria	2 tabs 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/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	3 capsules Per 28 days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 tab 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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nitrostat

Products Affected
- NITROSTAT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of nitroglycerin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Nocdurna

Products Affected
- NOCDURNA

PA Criteria	Criteria Details
Covered Uses	Initial Criteria Treatment of nocturia in adult patients with a documented diagnosis of nocturnal polyuria that meet all of the following: 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. 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;

PA Criteria	Criteria Details
	1. Serum sodium concentration was normal within 1 week after starting Nocdurna and again at 1 month after starting Nocdurna, AND 2. Patient has had a decrease in voiding episodes at night, AND 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 4. Patient does not have heart failure, AND 5. Patient does not have uncontrolled hypertension, AND 6. Patient is not pregnant, AND 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.
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

Notes/ References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Noctiva

Products Affected
- NOCTIVA

QL Criteria	1 bottle Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 09, 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

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

PA Criteria	Criteria Details
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

Norco

Products Affected

- NORCO ORAL TABLET 5-325 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	

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Northera

Products Affected

- NORTHERA ORAL CAPSULE 100 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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Northera.html
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

Northera

Products Affected
- NORTHERA ORAL CAPSULE 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/Northera.html
QL Criteria	6 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Noxafil

Products Affected

- NOXAFIL ORAL TABLET DELAYED RELEASE

QL Criteria	93 tablets 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

Nplate

Products Affected
- NPLATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/Neumega.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

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

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: immediate release oxycodone, hydromorphone, or morphine
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: immediate release oxycodone, hydromorphone, or morphine
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: immediate release oxycodone, hydromorphone, or morphine
QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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.
ST Criteria	FOR A DIAGNOSIS OF PAIN: A documented contraindication, intolerance, allergy, or failure of two of Butrans, Hysingla ER, or Oxycontin. FOR A DIAGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY: A documented contraindication, intolerance, allergy, or failure of Cymbalta and Lyrica.
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Nuedexta

Products Affected
- NUEDEXTA

QL Criteria	2 caps 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

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 07, 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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuvigil

Products Affected

- NUVIGIL 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

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

Nuvigil

Products Affected
- NUVIGIL 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

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

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

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_Cholagitis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Primary_Biliary_Cholagitis.html
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

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

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

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

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/ANEOPL/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

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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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 tab 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: February 14, 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: April 17, 2018

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl oral capsule 12-25 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 17, 2018

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl oral capsule 12-50 mg, 6-25 mg, 6-50 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

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Olumiant.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: June 27, 2018 Step Therapy: July 12, 2018 Quantity Limits: August 25, 2015

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

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

Omeprazole-Sodium Bicarbonate

Products Affected

- *omeprazole-sodium bicarbonate oral capsule 20-1100 mg*

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

Omnaris

Products Affected
- OMNARIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

OneTouch Ultra Blue

Products Affected
- ONETOUCH ULTRA BLUE

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

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

Onfi

Products Affected
- ONFI ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy and concomitant use of an anticonvulsant drug
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

Onfi

Products Affected
- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	Seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory (therapy resistant) epilepsy and concomitant use of an anticonvulsant drug
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 tabs 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

Onzetra Xsail

Products Affected
- ONZETRA XSAIL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of sumatriptan nasal spray
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

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

PA Criteria	Criteria Details
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

Opana

Products Affected
- OPANA 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

PA Criteria	Criteria Details
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

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	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oravig

Products Affected
- ORAVIG

QL Criteria	14 tabs 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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Orencia.html
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

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

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

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 08, 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 08, 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: September 19, 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

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

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

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

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: December 13, 2017

Osphena

Products Affected
- OSPHENA

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Otezla.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Otezla.html
QL Criteria	1 pack Per 1 year
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Otrexup

Products Affected

- OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 17.5 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Otrexup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	

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

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	

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

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of oxcarbazepine
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 600 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of oxcarbazepine
QL Criteria	4 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Oxybutynin Chloride

Products Affected

- *oxybutynin chloride 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

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

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

PA Criteria	Criteria Details
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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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	60 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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	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

PA Criteria	Criteria Details
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
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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	

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

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	

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

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	

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

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	

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

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

PA Criteria	Criteria Details
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

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	

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

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
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

Pancreaze

Products Affected
- PANCREAZE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Creon and Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 10 mg, 20 mg*

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

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 mg*

QL Criteria	2 tabs 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*

QL Criteria	2 tabs 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: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paxil

Products Affected
- PAXIL ORAL SUSPENSION

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

Paxil

Products Affected
- PAXIL ORAL TABLET 10 MG, 20 MG

QL Criteria	1 tab Per 1 Day
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 30 MG, 40 MG

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

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

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

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)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one systemic (oral) alternative such as terbinafine, itraconazole, or griseofulvin
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 - Value Plan
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 caps 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 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

Percocet

Products Affected

- PERCOCET 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	

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

Percocet

Products Affected

- PERCOCET 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	

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

Percocet

Products Affected

- PERCOCET 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	

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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	60 vials (120ml) Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Pertzye

Products Affected
- PERTZYE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Creon and Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Picato

Products Affected
- PICATO

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

Pioglitazone HCl

Products Affected
- *pioglitazone hcl*

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

Pioglitazone HCl-Glimepiride

Products Affected
- *pioglitazone hcl-glimepiride*

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

Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-metformin hcl*

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

Plavix

Products Affected
- PLAVIX ORAL TABLET 300 MG

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

Plavix

Products Affected
- PLAVIX ORAL TABLET 75 MG

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

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: March 16, 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

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/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	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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: March 16, 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Eliquis and Xarelto
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 16, 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/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCSK9.html
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

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 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

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er oral tablet extended release 24 hour 2.25 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

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

Pravachol

Products Affected

- PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

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

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

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

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

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

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

Prefest

Products Affected
- PREFEST

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

Prenate Mini

Products Affected

- PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 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

Products Affected

- PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 formulary alternative proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 06, 2017 Quantity Limits: January 18, 2018

Prevacid 24HR

Products Affected
- PREVACID 24HR

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 formulary alternative proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 02/2017

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

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015

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: January 10, 2018

Prezista

Products Affected
- PREZISTA ORAL SUSPENSION

QL Criteria	2 bottles Per 30 Days
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 tabs 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 800 MG

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

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tab Per 1 day

2018 Aetna Pharmacy Drug Guide - Value Plan
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: February 18, 2018 Quantity Limits: August 25, 2015

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 Day

2018 Aetna Pharmacy Drug Guide - Value Plan
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: February 18, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Procardia XL

Products Affected

- PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 90 MG

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

Procardia XL

Products Affected

- PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG

QL Criteria	2 tabs 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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	40 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

Procrit

Products Affected
- PROCRIT

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
QL Criteria	240 caps Per 30 monthss
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/lysosomal_storage.html
QL Criteria	750 caps Per 30 monthss
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Prolastin-C

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION
- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected
- PROMACTA

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 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of dutasteride or finasteride
Notes/ References	
Revision Date	Prior Authorization: March 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Protonix

Products Affected
- PROTONIX ORAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 formulary alternative proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015

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	

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition. Preferred topical corticosteroids include triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment.
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Proventil HFA

Products Affected
- PROVENTIL HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of Ventolin HFA and Proair
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Provigil

Products Affected
- PROVIGIL

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

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 tabs 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

PROzac

Products Affected

- PROZAC ORAL CAPSULE 10 MG

QL Criteria	1 cap 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 20 MG

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

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

Psorcon

Products Affected

- *psorcon*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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 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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and Qvar
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

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	60 units Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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	
ST Criteria	Documented contraindication, intolerance, allergy, or failure of 1 month of topical aluminum chloride.
QL Criteria	1 pad Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: November 10, 2018 Quantity Limits: November 25, 2018

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

Qnasl

Products Affected
- QNASL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl Childrens

Products Affected
- QNASL CHILDRENS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qudexy XR

Products Affected

- QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 25 MG, 50 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of generic topiramate
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Qudexy XR

Products Affected

- QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 150 MG, 200 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of generic topiramate
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 100 mg, 50 mg*

QL Criteria	3 tabs 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 200 mg*

QL Criteria	4 tabs 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 tabs 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 300 mg, 400 mg*

QL Criteria	2 tabs 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

QUEtiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 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 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 29, 2018

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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 - Value Plan
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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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 - Value Plan
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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 bottle Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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: January 09, 2018

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

QL Criteria	1 tab 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

Ranexa

Products Affected
- RANEXA

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

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

Rasuvo

Products Affected

- RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Otrexup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of calcitriol
QL Criteria	1 capsule 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

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

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

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 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Rectiv

Products Affected
- RECTIV

QL Criteria	30 grams Per 1 fill
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

Relenza Diskhaler

Products Affected
- RELENZA DISKHALER

QL Criteria	20 inhalations Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 06, 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

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 concommitant 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

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 concommitant 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

Relpax

Products Affected
- RELPAX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of three of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan
QL Criteria	6 tablets Per 30 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Remicade.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Renflexis.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCSK9.html
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

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/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCSK9.html
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

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/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/PCSK9.html
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

Requip XL

Products Affected

- REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG

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

Requip XL

Products Affected

- REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HOUR 2 MG, 4 MG, 6 MG, 8 MG

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

Retacrit

Products Affected
- RETACRIT

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin and Epiduo
Notes/ References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Value Plan
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: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Value Plan
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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin and Epiduo
Notes/ References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Value Plan
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: August 25, 2015

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin and Epiduo
Notes/ References	Annual Review: 07/2018

2018 Aetna Pharmacy Drug Guide - Value Plan
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: August 25, 2015

Revatio

Products Affected
- REVATIO INTRAVENOUS

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

Revatio

Products Affected

- 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
QL Criteria	3 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 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/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	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

Reyataz

Products Affected
- REYATAZ ORAL CAPSULE 150 MG

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 08, 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

Reyataz

Products Affected
- REYATAZ ORAL CAPSULE 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

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

Rhopressa

Products Affected
- RHOPRESSA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost or one week of Travatan Z
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: May 21, 2018 Quantity Limits: August 25, 2015

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

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

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

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
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

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 30 mg, 5 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
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

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 35 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
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

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet delayed release*

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

RisperDAL

Products Affected
- RISPERDAL ORAL TABLET 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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	3 tabs Per 1 day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	4 tabs Per 1 day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

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 tabs 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 tabs 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 4 mg*
- *risperidone oral tablet dispersible 4 mg*

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

Ritalin

Products Affected
- RITALIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	6 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

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 cap 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

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 30 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules 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

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

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

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

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: January 11, 2018

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release 24 hour 12 mg*

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

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

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

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

PA Criteria	Criteria Details
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
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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

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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of two short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	4 tablets Per 1 day over 7 days
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: October 15, 2018 Quantity Limits: October 29, 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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of two short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	2 tablets Per 1 day over 7 days
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: October 15, 2018 Quantity Limits: October 29, 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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of two short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	6 tablets Per 1 day over 7 days
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: October 15, 2018 Quantity Limits: October 29, 2018

Rozerem

Products Affected
- ROZEREM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 28, 2018 Quantity Limits: August 25, 2015

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/ANEOPL/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	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/ANEOPL/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

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

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

Rythmol SR

Products Affected
- RYTHMOL SR

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

Sabril

Products Affected
- SABRIL

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 packs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sancuso

Products Affected
- SANCUSO

QL Criteria	1 patch 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

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

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
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

Savaysa

Products Affected
- SAVAYSA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Eliquis and Xarelto
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 16, 2018

Savella

Products Affected
- SAVELLA

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of fibromyalgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of duloxetine and Lyrica
QL Criteria	2 tabs 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

Savella Titration Pack

Products Affected
- SAVELLA TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of fibromyalgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of duloxetine and Lyrica
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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Spiriva and Incruse Ellipta
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

Selzentry

Products Affected
- SELZENTRY ORAL TABLET 150 MG

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

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

Selzentry

Products Affected
- SELZENTRY ORAL TABLET 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

Sensipar

Products Affected
- SENSIPAR

PA Criteria	Criteria Details
Covered Uses	Secondary Hyperparathyroidism (HPT) in adult patients with chronic kidney disease (CKD) on dialysis, Hypercalcemia in adult patients with Parathyroid Carcinoma, or Hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of Secondary Hyperparathyroidism (HPT) in an adult patient with chronic kidney disease (CKD) on dialysis,Hypercalcemia in an adult patient with parathyroid carcinoma (PC), or Hypercalcemia in an adult patient with primary hyperparathyroidism for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Serevent Diskus

Products Affected
- SEREVENT DISKUS

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

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISDOES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	3 tabs Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 24, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISDOES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	4 tabs Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 24, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISDOES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	6 EA Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 24, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

SEROquel

Products Affected
- SEROQUEL ORAL TABLET 300 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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISDOES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	2 EA Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 24, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

SEROquel

Products Affected
- SEROQUEL ORAL TABLET 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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISDOES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 24, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG

ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR BIPOLAR DEPRESSION: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG, 400 MG

ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR BIPOLAR DEPRESSION: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50 MG

ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR BIPOLAR DEPRESSION: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 07, 2017 Quantity Limits: August 29, 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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

QL Criteria	2 tabs 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 25 mg*

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

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 amps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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 contraindicaiton, 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

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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Siliq.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Simponi.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Simponi_Aria.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simvastatin

Products Affected
- *simvastatin oral*

QL Criteria	1 tab 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

Singulair

Products Affected
- SINGULAIR ORAL TABLET

QL Criteria	1 tab 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 TABLET CHEWABLE

QL Criteria	1 tab 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 tabs Per 365 dayss
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sivextro

Products Affected
- SIVEXTRO ORAL

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

Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*

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

Sodium Phenylbutyrate

Products Affected
- *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	
QL Criteria	40 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2018

Soliqua

Products Affected
- SOLIQUA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one of the following: Victoza, Byetta, Bydureon, Tanzeum, Trulicity, Adylixin , Lantus, Toujeo, Levemir, Tresiba, or Basaglar
QL Criteria	5 pens Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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/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

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

Soolantra

Products Affected
- SOOLANTRA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred topical generic alternatives, metronidazole or sulfacetamide sodium with sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Soriatane

Products Affected
- SORIATANE ORAL CAPSULE 10 MG

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

Soriatane

Products Affected
- SORIATANE ORAL CAPSULE 25 MG

QL Criteria	2 caps Per 1 day
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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 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: February 14, 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

Spritam

Products Affected
- SPRITAM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of immediate release levitiracetam tablets
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

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Stelara.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Stelara.html
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Stelara.html
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

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

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/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	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG, 60 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules 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

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 100 MG, 80 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 capsule 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

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

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 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent
QL Criteria	1 inhaler Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 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

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: July 30, 2018

Sular

Products Affected

- SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG

QL Criteria	1 tab 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 tablet*

QL Criteria	8 tabs 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 tablet delayed release*

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

Sulfazine

Products Affected
- SULFAZINE

QL Criteria	8 tabs 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: September 19, 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: September 19, 2018

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: July 17, 2018

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution auto-injector 4 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: July 17, 2018

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution auto-injector 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: January 11, 2018

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

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

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/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	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected
- SUTENT ORAL CAPSULE 37.5 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	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected
- SUTENT 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/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	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Symbicort

Products Affected
- SYMBICORT

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

Symbyax

Products Affected

- SYMBYAX ORAL CAPSULE 12-25 MG, 12-50 MG, 6-25 MG, 6-50 MG

QL Criteria	1 cap 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: March 19, 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 - Value Plan
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 01, 2018

SymlinPen 60

Products Affected

- SYMLINPEN 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 - Value Plan
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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Movantik
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 06, 2017 Step Therapy: November 06, 2017 Quantity Limits: August 25, 2015

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

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

Synalar

Products Affected
- SYNALAR EXTERNAL CREAM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alclometasone cream/ointment
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Synalar

Products Affected
- SYNALAR EXTERNAL OINTMENT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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

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

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

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

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

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	

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition. Preferred topical corticosteroids include triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment.
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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)

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

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

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/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	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Taltz.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Talzenna

Products Affected
- TALZENNA ORAL CAPSULE 0.25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletine for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/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

Talzenna

Products Affected
- TALZENNA ORAL CAPSULE 1 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletine for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/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

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

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: March 15, 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/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	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Targretin

Products Affected
- TARGRETIN ORAL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/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

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	4 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
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

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

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: April 04, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG, 360 MG

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

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 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Technivie.html
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: May 25, 2018 Quantity Limits: August 25, 2015

Tekturna

Products Affected
- TEKTURNA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two preferred ACE-I or ARB . Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril),Univasc (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan) , Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Tekturna HCT

Products Affected
- TEKTURNA HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two preferred ACE-I or ARB . Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril),Univasc (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan) , Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Telmisartan

Products Affected
- *telmisartan*

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

Telmisartan-Amlodipine

Products Affected

- *telmisartan-amlodipine*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand, Avapro, Cozaar, Micardis
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Telmisartan-HCTZ

Products Affected
- *telmisartan-hctz*

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

Temazepam

Products Affected

- *temazepam oral capsule 22.5 mg, 7.5 mg*

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

Temovate

Products Affected

- TEMOVATE EXTERNAL CREAM
- TEMOVATE EXTERNAL OINTMENT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 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/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

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: January 10, 2018

Testosterone

Products Affected

- *testosterone transdermal gel 10 mg/act (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

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal gel 12.5 mg/act (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

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

Testosterone

Products Affected

- *testosterone transdermal gel 20.25 mg/1.25gm (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: November 20, 2018

Testosterone

Products Affected

- *testosterone transdermal gel 20.25 mg/act (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

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

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%
QL Criteria	6 ml Per 1 day

2018 Aetna Pharmacy Drug Guide - Value Plan
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

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 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 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/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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/metabolic_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 12 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 17, 2018

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

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

TiaGABine HCl

Products Affected

- *tiagabine hcl 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

Tiazac

Products Affected

- TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG, 360 MG, 420 MG

QL Criteria	1 cap 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 240 MG

QL Criteria	2 caps 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/ANEOPL/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 08, 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

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

Tivicay

Products Affected
- TIVICAY ORAL TABLET 50 MG

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

Tobi

Products Affected
- TOBI

QL Criteria	56 vials Per 1 fill
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 box Per 28 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tobramycin

Products Affected

- *tobramycin inhalation*

QL Criteria	56 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

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

Topamax Sprinkle

Products Affected
- TOPAMAX SPRINKLE

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

Topicort

Products Affected

- TOPICORT EXTERNAL CREAM
- TOPICORT EXTERNAL OINTMENT
- TOPICORT EXTERNAL GEL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Topiramate

Products Affected

- *topiramate oral capsule sprinkle*

QL Criteria	4 caps 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of metoprolol succinate
QL Criteria	1.5 tabs 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 200 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of metoprolol succinate
QL Criteria	2 tabs 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of metoprolol succinate
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toviaz

Products Affected
- TOVIAZ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Tracleer

Products Affected
- TRACLEER

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

Tradjenta

Products Affected
- TRADJENTA

QL Criteria	1 tab 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

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

PA Criteria	Criteria Details
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

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	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	

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

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	

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

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

PA Criteria	Criteria Details
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

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

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

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Tremfya.html
QL Criteria	1 injection Per 2 months
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 - Value Plan
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

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 - Value Plan
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

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	

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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 01, 2018

Tribenzor

Products Affected
- TRIBENZOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand HCT, Avalide, Hyzaar, Micardis HCT
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Tricor

Products Affected
- TRICOR

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

Tridesilon

Products Affected
- TRIDESILON

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alclometasone cream/ointment
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 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

Triglide

Products Affected
- TRIGLIDE ORAL TABLET 160 MG

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

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Value Plan
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

Triumeq

Products Affected
- TRIUMEQ

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: October 15, 2018 Quantity Limits: August 25, 2015

Trokendi XR

Products Affected

- TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 25 MG, 50 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of generic topiramate
QL Criteria	1 cap Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Trokendi XR

Products Affected

- TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of generic topiramate
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: September 19, 2018

Trospium Chloride

Products Affected
- *trospium chloride*

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

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of, or concommitant therapy with, Metformin/XR
QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Spiriva and Incruse Ellipta
QL Criteria	1 inhaler Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: February 18, 2018 Quantity Limits: March 15, 2018

TussiCaps

Products Affected

- TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 10-8 MG

QL Criteria	20 caps 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

Twynsta

Products Affected
- TWYNSTA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand, Avapro, Cozaar, Micardis
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Tybost

Products Affected
- TYBOST

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

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/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

Tylenol with Codeine #3

Products Affected
- TYLENOL WITH 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

PA Criteria	Criteria Details
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

Tylenol with Codeine #4

Products Affected
- TYLENOL WITH 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

PA Criteria	Criteria Details
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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
QL Criteria	2 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CNS/Tysabri.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
QL Criteria	1 amp Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
QL Criteria	1 amp Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/pulmonaryhypertensionagents.html
QL Criteria	1 amp Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uceris

Products Affected
- UCERIS ORAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: January 30, 2018 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	4 canisters Per 42 months
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of allopurinol
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

PA Criteria	Criteria Details
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

Ultram

Products Affected
- ULTRAM

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

PA Criteria	Criteria Details
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

Ultravate

Products Affected

- ULTRAVATE EXTERNAL CREAM OINTMENT
- ULTRAVATE EXTERNAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	50 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 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

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 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uptravi

Products Affected

- UPTRAVI ORAL TABLET 200 MCG PACK
- UPTRAVI ORAL TABLET THERAPY

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

Uroxatral

Products Affected
- UROXATRAL

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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Anoro Ellipta and Stiolto
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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/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	4 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: March 16, 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 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

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

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

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

Valsartan-Hydrochlorothiazide

Products Affected

- *valsartan-hydrochlorothiazide*

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

Valtrex

Products Affected
- VALTREX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic valacyclovir
Notes/ References	Annual Review: 07/2018
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

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

Vascepa

Products Affected
- VASCEPA ORAL CAPSULE 1 GM

QL Criteria	4 caps Per 1 Day
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/CV/antihypertensive_misc.html
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Notes/ References	
Revision Date	Prior Authorization: August 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Veltin

Products Affected
- VELTIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Vemlidy.html
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

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/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	40 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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/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	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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	1 pack Per 28 days
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

QL Criteria	3 tabs 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 tabs 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 50 mg*

QL Criteria	6 tabs 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 tabs 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 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 cap 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 150 mg*

QL Criteria	2 tab 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, 37.5 mg, 75 mg*

QL Criteria	1 tab 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

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg*

QL Criteria	1 cap 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 caps Per 1 day
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 - Value Plan
The formulary is updated the first week of each month.
12/01/2018

PA Criteria	Criteria Details
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

Verelan PM

Products Affected

- VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 300 MG

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

Verelan PM

Products Affected

- VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG

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

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic clozapine tablets
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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/ANEOPL/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: November 14, 2017

VESIcare

Products Affected
- VESICARE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin)
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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

PA Criteria	Criteria Details
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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of, or concommitant therapy with, Metformin/XR
QL Criteria	3 pens Per 30 Days
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: February 26, 2018 Quantity Limits: April 11, 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Viekira.html
Notes/ References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: May 25, 2018 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/GI/Viekira.html
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 25, 2018 Step Therapy: May 25, 2018 Quantity Limits: August 25, 2015

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

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

Viibryd

Products Affected
- VIIBRYD ORAL TABLET

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

Viibryd Starter Pack

Products Affected
- VIIBRYD STARTER PACK

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.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

Vimpat

Products Affected
- VIMPAT ORAL SOLUTION

QL Criteria	40 ml Per 1 Day
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 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viokace

Products Affected
- VIOKACE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Creon and Zenpep
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 100 MG

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

Viread

Products Affected

- VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG

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

Viread

Products Affected
- VIREAD ORAL TABLET 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: January 10, 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

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/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

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

Vizimpro

Products Affected
- VIZIMPRO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletine for details: http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/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

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

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

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

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/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	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	4 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 31, 2018 Quantity Limits: August 25, 2015

2018 Aetna Pharmacy Drug Guide - Value Plan
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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	2 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 31, 2018 Quantity Limits: August 25, 2015

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 31, 2018 Quantity Limits: August 25, 2015

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 31, 2018 Quantity Limits: August 25, 2015

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

Vytorin

Products Affected

- VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic simvastatin in combination with generic ezetimibe, or generic ezetimibe-simvastatin
QL Criteria	1 tab 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

Vytorin

Products Affected

- VYTORIN ORAL TABLET 10-80 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic simvastatin in combination with generic ezetimibe, or generic ezetimibe-simvastatin
QL Criteria	1 tab 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

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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 21, 2018 Quantity Limits: August 25, 2015

Wellbutrin SR

Products Affected
- WELLBUTRIN SR

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

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

Xadago

Products Affected
- XADAGO

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment to levodopa/carbidopa in patients with Parkinsons disease (PD) experiencing "off" episodes
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Parkinsons disease and concurrent use of levodopa/carbidopa
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of rasagaline or selegiline
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

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 21, 2018 Quantity Limits: August 25, 2015

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/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 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto

Products Affected

- XARELTO 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: July 16, 2018

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: March 16, 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: November 20, 2018

Xarelto

Products Affected

- XARELTO 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: March 16, 2018

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: March 16, 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

Xeljanz

Products Affected
- XELJANZ 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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Xeljanz_XeljanzXR.html
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

Xeljanz

Products Affected
- XELJANZ 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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	60 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	30 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/xenazine.html
QL Criteria	8 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/xenazine.html
QL Criteria	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected
- XIFAXAN ORAL TABLET 200 MG

QL Criteria	9 tabs 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

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 ENCHEPHALOPATHY: 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

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: February 08, 2018

Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 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

Xodol

Products Affected

- XODOL ORAL TABLET 5-300 MG, 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	

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

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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/RESP/Xolair.html
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xopenex HFA

Products Affected
- XOPENEX HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of Ventolin HFA and Proair
QL Criteria	2 inhalers 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

Xtampza ER

Products Affected
- XTAMPZA 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

PA Criteria	Criteria Details
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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Antineoplastics.html
QL Criteria	4 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xultophy

Products Affected
- XULTOPHY

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one of the following: Victoza, Byetta, Bydureon, Tanzeum, Trulicity, Adylixin , Lantus, Toujeo, Levemir, Tresiba, or Basaglar
QL Criteria	5 pens Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 18, 2018 Quantity Limits: August 25, 2015

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

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

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

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/cataplexy-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

Xyzal Allergy 24HR

Products Affected
- XYZAL ALLERGY 24HR

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: October 16, 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/Yonsa.html
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: June 07, 2018 Step Therapy: June 07, 2018 Quantity Limits: August 25, 2015

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

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

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 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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/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	8 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Zembrace SymTouch

Products Affected
- ZEMBRACE SYMTOUCH

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic Imitrex injection
QL Criteria	8 syringes/1 month Per 48 max in 365 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: September 19, 2018

Zemplar

Products Affected

- ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of paricalcitol and calcitriol
QL Criteria	1 cap 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

Zenzedi

Products Affected

- ZENZEDI ORAL TABLET 10 MG, 5 MG

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

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

Zetia

Products Affected
- ZETIA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of ezetimibe
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

Zetonna

Products Affected
- ZETONNA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziana

Products Affected
- ZIANA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: May 21, 2018 Quantity Limits: August 25, 2015

Ziprasidone HCl

Products Affected
- *ziprasidone hcl*

QL Criteria	2 caps 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 06, 2018 Quantity Limits: August 25, 2015

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	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	

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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

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/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	4 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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: January 11, 2018

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 100 MG

QL Criteria	2 tabs 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 25 MG

QL Criteria	1 tab 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 tag 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 oral*

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

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 28, 2018 Quantity Limits: August 25, 2015

Zomacton

Products Affected
- ZOMACTON

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2018/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected
- ZOMIG NASAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of three of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan
QL Criteria	6 sprays Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 11, 2018

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 11, 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 11, 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

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 tab 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

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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 tabs 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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
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

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of allopurinol or febuxostat
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 04, 2017 Quantity Limits: August 25, 2015

Zyban

Products Affected
- ZYBAN

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 09, 2018

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/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

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

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/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

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISDOES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 24, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

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
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR A DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISDOES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda.
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018

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

Revision Date	Prior Authorization: August 24, 2018 Step Therapy: November 07, 2017 Quantity Limits: August 25, 2015

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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	1 tab 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

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/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	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/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

Zyvox

Products Affected

- ZYVOX 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

Zyvox

Products Affected
- ZYVOX ORAL TABLET

QL Criteria	28 tabs 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
ABSTRAL....2
acamprosate calcium....4
ACCOLATE....5
acetaminophen-codeine #2....12
acetaminophen-codeine #3....14
acetaminophen-codeine #4....16
acetaminophen-codeine oral solution....6
acetaminophen-codeine oral tablet 300-15 mg....8
acetaminophen-codeine oral tablet 300-60 mg....10
ACIPHEX....18
ACIPHEX SPRINKLE....20
acitretin oral capsule 10 mg, 25 mg....22
acitretin oral capsule 17.5 mg....23
ACTEMRA INTRAVENOUS....24
ACTEMRA SUBCUTANEOUS....25
ACTIMMUNE....26
ACTIQ....27
ACTIVELLA....29
ACTONEL ORAL TABLET 150 MG....30
ACTONEL ORAL TABLET 30 MG, 5 MG....31
ACTONEL ORAL TABLET 35 MG....32
ACTOPLUS MET....33
ACTOPLUS MET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 15-1000 MG....34
ACTOPLUS MET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 30-1000 MG....35
ACTOS....36
ACZONE....37
ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 90 MG....38
ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG....39
ADCIRCA....40
ADDERALL....41
ADDERALL XR....42
adefovir dipivoxil....43
ADEMPAS....44
ADVAIR DISKUS....45
ADVAIR HFA....46
ADVATE....47
ADYNOVATE....48
ADYPHREN....49
ADYPHREN AMP II....50
ADYPHREN II....51
ADZENYS ER....52
ADZENYS XR-ODT....53
AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG....54
AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG....55
AFINITOR....56
AFINITOR DISPERZ....57
AFREZZA INHALATION POWDER 12 UNIT, 8 UNIT....58
AFREZZA INHALATION POWDER 4 & 8 & 12 UNIT, 4 (90) & 8 (90) UNIT, 4 UNIT....59
AFSTYLA....60
AIMOVIG....61
AIMOVIG 140 DOSE....62
AIRDUO RESPICLICK 113/14....63
AIRDUO RESPICLICK 232/14....64
AIRDUO RESPICLICK 55/14....65
AJOVY....66
AKYNZEO ORAL....67
albendazole oral....68
ALBENZA....69
ALDARA....70
ALDURAZYME....71
ALECENSA....72
alendronate sodium oral tablet 10 mg....73
alendronate sodium oral tablet 35 mg....74

alendronate sodium oral tablet 40 mg, 5 mg 75
alendronate sodium oral tablet 70 mg 76
alfuzosin hcl er 77
ALINIA ORAL SUSPENSION RECONSTITUTED 78
ALINIA ORAL TABLET 79
ALKERAN ORAL 80
almotriptan malate 81
alogliptin benzoate 82
alogliptin-metformin hcl 83
alogliptin-pioglitazone 84
ALORA 85
alosetron hcl 86
ALPHANATE/VWF COMPLEX/HUMAN 87
ALPHANINE SD 88
alprazolam er 89
alprazolam xr 90
ALPROLIX 91
ALTOPREV 92
ALUNBRIG ORAL TABLET 180 MG 93
ALUNBRIG ORAL TABLET 30 MG 94
ALUNBRIG ORAL TABLET 90 MG 95
ALUNBRIG ORAL TABLET THERAPY PACK 95
ALVESCO 96
AMABELZ 97
AMBIEN 98
AMBIEN CR 99
amcinonide external cream 100
amcinonide external lotion 100
AMERGE 101
AMITIZA 102
amlodipine besylate-valsartan 103
amlodipine-olmesartan 104
amlodipine-valsartan-hctz 105
amnesteem 106
amphetamine sulfate 107
amphetamine-dextroamphet er 108
amphetamine-dextroamphetamine 109
ANORO ELLIPTA 110
ANTARA ORAL CAPSULE 30 MG, 90 MG 111
ANZEMET ORAL 112
apap-caff-dihydrocodeine oral capsule 113
APEXICON E 115
aprepitant oral capsule 125 mg, 40 mg, 80 mg 116
aprepitant oral capsule 80 & 125 mg 117
APRISO 118
APTENSIO XR 119
APTIOM ORAL TABLET 200 MG 120
APTIOM ORAL TABLET 400 MG 121
APTIOM ORAL TABLET 600 MG 122
APTIOM ORAL TABLET 800 MG 123
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG 124
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML 125
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 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 125
ARAVA 126
ARCALYST 127
ARCAPTA NEOHALER 128
ARICEPT 129
aripiprazole oral solution 130
aripiprazole oral tablet 131
aripiprazole oral tablet dispersible 131
ARIXTRA 132
armodafinil oral tablet 150 mg, 200 mg, 250 mg 133
armodafinil oral tablet 50 mg 135
ARMONAIR RESPICLICK 113 137
ARMONAIR RESPICLICK 232 138

ARMONAIR RESPICLICK 55 139
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT 140
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT 141
ARYMO ER ORAL TABLET EXTENDED RELEASE ABUSE-DETERRENT 15 MG, 30 MG 142
ARYMO ER ORAL TABLET EXTENDED RELEASE ABUSE-DETERRENT 60 MG 144
ASACOL HD 146
ASCOMP-CODEINE 147
ASMANEX 120 METERED DOSES ... 149
ASMANEX 14 METERED DOSES 150
ASMANEX 30 METERED DOSES 151
ASMANEX 60 METERED DOSES 152
ASMANEX 7 METERED DOSES 153
ASMANEX HFA 154
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG 155
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 1 MG 156
ATACAND 157
atazanavir sulfate oral capsule 150 mg 158
atazanavir sulfate oral capsule 200 mg 159
atazanavir sulfate oral capsule 300 mg 160
ATELVIA 161
atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg 162
atomoxetine hcl oral capsule 100 mg, 80 mg 163
atorvastatin calcium oral 164
ATRIPLA 165
ATROVENT HFA 166
AUBAGIO 167
AUSTEDO 168
AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG 169
AVANDIA ORAL TABLET 2 MG, 4 MG 170
AVAPRO 171
avita 172
AVODART 173
AVONEX 174
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 175
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 176
AZILECT 177
AZOR 178
AZULFIDINE 179
AZULFIDINE EN-TABS 180
BACTROBAN EXTERNAL CREAM . 181
balsalazide disodium 182
BANZEL ORAL SUSPENSION 183
BANZEL ORAL TABLET 184
BARACLUDE ORAL TABLET 185
BAXDELA ORAL 186
BEBULIN 187
BECONASE AQ 188
BELBUCA 189
BELSOMRA 191
BENEFIX INTRAVENOUS KIT 192
BENICAR 193
BENICAR HCT 194
BENLYSTA INTRAVENOUS 195
BENLYSTA SUBCUTANEOUS 196
benznidazole oral tablet 100 mg 197
benznidazole oral tablet 12.5 mg 198
BERINERT 199
betamethasone dipropionate aug external gel 200
betamethasone dipropionate aug external lotion 201
betamethasone dipropionate aug external ointment 200
betamethasone valerate external cream ... 202

betamethasone valerate external lotion 202
betamethasone valerate external ointment 202
BETASERON SUBCUTANEOUS KIT 203
BETHKIS 204
BEVESPI AEROSPHERE 205
BEVYXXA 206
bexarotene 207
bicalutamide 208
BIKTARVY 209
bimatoprost ophthalmic 210
BIVIGAM 211
BONIVA ORAL TABLET 150 MG 212
BONJESTA 213
BOSULIF ORAL TABLET 100 MG 214
BOSULIF ORAL TABLET 400 MG 215
BOSULIF ORAL TABLET 500 MG 216
BOTOX 217
BRAFTOVI ORAL CAPSULE 50 MG 218
BRAFTOVI ORAL CAPSULE 75 MG 219
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH 220
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/INH 221
BRILINTA ORAL TABLET 60 MG 222
BRILINTA ORAL TABLET 90 MG 223
BRISDELLE 224
BRIVIACT ORAL SOLUTION 225
BRIVIACT ORAL TABLET 226
BROVANA 227
budesonide er oral tablet extended release 24 hour 229
budesonide inhalation 228
BUNAVAIL BUCCAL FILM 2.1-0.3 MG 230
BUNAVAIL BUCCAL FILM 4.2-0.7 MG 231
BUNAVAIL BUCCAL FILM 6.3-1 MG 232
BUPHENYL ORAL POWDER 3 GM/TSP 233
BUPHENYL ORAL TABLET 234
buprenorphine 235
buprenorphine hcl sublingual 237
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 238
bupropion hcl er (smoking det) 240
bupropion hcl er (sr) 241
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg 242
bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg 243
bupropion hcl oral 239
butalbital-apap-caff-cod 244
butalbital-asa-caff-codeine 246
butorphanol tartrate nasal 248
BUTRANS 250
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 5 MG 252
BYSTOLIC ORAL TABLET 20 MG 253
BYVALSON 254
CABOMETYX 255
calcipotriene external cream 256
calcipotriene external ointment 256
calcitonin (salmon) 257
calcitrene 258
CALQUENCE 259
CANASA 260
candesartan cilexetil 261
candesartan cilexetil-hctz 262
capecitabine 263
CAPRELSA ORAL TABLET 100 MG 264
CAPRELSA ORAL TABLET 300 MG 265
CARBAGLU 266
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG, 360 MG 267
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 240 MG 268
CARDURA XL 269

CARIMUNE NF INTRAVENOUS SOLUTION RECONSTITUTED 12 GM, 6 GM 270
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG 271
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG 272
carvedilol phosphate er 273
CASODEX 274
CAYSTON 275
CELEBREX 276
celecoxib oral 277
CELEXA ORAL TABLET 278
CENTANY 279
CERDELGA 280
CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT 281
CESAMET 282
cevimeline hcl 283
CHANTIX 284
CHANTIX CONTINUING MONTH PAK 285
CHENODAL 286
CHOLBAM 288
CIMDUO 289
CIMZIA PREFILLED 291
CIMZIA STARTER KIT 292
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG 290
CINQAIR 293
CINRYZE 294
citalopram hydrobromide oral tablet 10 mg, 20 mg 295
citalopram hydrobromide oral tablet 40 mg 296
CLARAVIS ORAL CAPSULE 10 MG, 30 MG 297
claravis oral capsule 20 mg, 40 mg 297
CLARINEX ORAL TABLET 298
CLARINEX-D 12 HOUR 299
CLEOCIN-T EXTERNAL GEL 300
CLEOCIN-T EXTERNAL LOTION 300
CLEOCIN-T EXTERNAL SOLUTION 300
CLIMARA 301
CLIMARA PRO 302
CLINDAGEL 303
clindamycin phosphate external gel 304
clindamycin phosphate external lotion 304
clindamycin phosphate external solution 304
clobetasol propionate e 311
clobetasol propionate emulsion 312
clobetasol propionate external cream 305
clobetasol propionate external foam 306
clobetasol propionate external gel 305
clobetasol propionate external liquid 307
clobetasol propionate external lotion 308
clobetasol propionate external ointment 305
clobetasol propionate external shampoo 309
clobetasol propionate external solution 310
CLOBEX EXTERNAL LOTION 313
CLOBEX EXTERNAL SHAMPOO 314
CLOBEX SPRAY 315
clodan external shampoo 316
clonidine hcl er 317
clopidogrel bisulfate oral tablet 300 mg 318
clopidogrel bisulfate oral tablet 75 mg 319
clozapine oral tablet 100 mg 320
clozapine oral tablet 200 mg 321
clozapine oral tablet 25 mg, 50 mg 322
clozapine oral tablet dispersible 100 mg 320
clozapine oral tablet dispersible 12.5 mg 323
clozapine oral tablet dispersible 150 mg 324
clozapine oral tablet dispersible 200 mg 325
clozapine oral tablet dispersible 25 mg 322
CLOZARIL ORAL TABLET 100 MG 326
CLOZARIL ORAL TABLET 25 MG 327
COAGADEX 328
codeine sulfate oral tablet 15 mg 329
codeine sulfate oral tablet 30 mg 331
codeine sulfate oral tablet 60 mg 333

COLAZAL 335
colchicine oral 336
COMBIPATCH 337
COMBIVENT RESPIMAT 338
COMETRIQ (100 MG DAILY DOSE) 339
COMETRIQ (140 MG DAILY DOSE) 340
COMETRIQ (60 MG DAILY DOSE) .. 341
COMPLERA 342
CONCERTA ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 54 MG 343
CONCERTA ORAL TABLET EXTENDED RELEASE 36 MG 344
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML 345
COPIKTRA 346
CORDRAN EXTERNAL CREAM 0.05 % 347
CORDRAN EXTERNAL LOTION 348
CORDRAN EXTERNAL OINTMENT 349
CORDRAN EXTERNAL TAPE 350
COREG CR 351
CORIFACT 352
CORLANOR 353
COSENTYX 354
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML 355
COTELLIC 356
COTEMPLA XR-ODT 357
COZAAR ORAL TABLET 100 MG 358
COZAAR ORAL TABLET 25 MG, 50 MG 359
CRESTOR 360
CUPRIMINE ORAL CAPSULE 250 MG 361
CUVITRU 362
CYCLOSET 363
CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 20 MG 364
CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 30 MG 365
CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 60 MG 366
CYSTADANE 367
CYSTAGON 368
CYSTARAN 369
DAKLINZA ORAL TABLET 30 MG, 60 MG 370
DAKLINZA ORAL TABLET 90 MG. 371
dalfampridine er 372
DALIRESP ORAL TABLET 250 MCG 373
DALIRESP ORAL TABLET 500 MCG 374
dapsone external 375
darifenacin hydrobromide er 376
DAYTRANA 377
DELSTRIGO 378
DELZICOL 379
DEMSER 380
DEPEN TITRATABS 381
DESCOVY 382
desloratadine oral tablet 383
desloratadine oral tablet dispersible 2.5 mg 383
desonide external 384
DESOWEN EXTERNAL CREAM 385
DESOWEN EXTERNAL LOTION 385
desoximetasone external cream 386
desoximetasone external gel 386
desoximetasone external ointment 386
DESOXYN 387
desvenlafaxine er 388
desvenlafaxine succinate er 390
DETROL 392
DETROL LA 393

DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 394
dexmethylphenidate hcl 395
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg 396
dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg, 35 mg 397
dextroamphetamine sulfate er 400
dextroamphetamine sulfate oral solution 398
dextroamphetamine sulfate oral tablet 399
DIASTAT ACUDIAL 401
DIASTAT PEDIATRIC 402
diazepam rectal 403
DIBENZYLINE 404
DICLEGIS 405
diclofenac sodium transdermal gel 1 % 406
DIFFERIN EXTERNAL GEL 0.3 % 407
DIFFERIN EXTERNAL LOTION 407
DIFICID 408
diflorasone diacetate external cream 409
diflorasone diacetate external ointment 410
dihydroergotamine mesylate nasal 411
DILAUDID ORAL LIQUID 412
DILAUDID ORAL TABLET 2 MG 414
DILAUDID ORAL TABLET 4 MG 416
DILAUDID ORAL TABLET 8 MG 418
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg 421
diltiazem hcl er beads oral capsule extended release 24 hour 240 mg 422
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 360 mg 423
diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg, 300 mg 426
diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg 427
diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 300 mg, 360 mg 424
diltiazem hcl er coated beads oral tablet extended release 24 hour 240 mg 425
diltiazem hcl er oral capsule extended release 24 hour 240 mg 420
dilt-xr oral capsule extended release 24 hour 240 mg 428
DIOVAN 429
DIOVAN HCT 430
DIPENTUM 431
DIPROLENE EXTERNAL LOTION 432
DIPROLENE EXTERNAL OINTMENT 433
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG 434
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG 435
DIVIGEL 436
DOLOPHINE ORAL TABLET 10 MG 437
DOLOPHINE ORAL TABLET 5 MG 440
donepezil hcl 443
DOPTELET ORAL TABLET 20 MG 444
DOVONEX EXTERNAL CREAM 445
doxepin hcl external 446
doxercalciferol oral 447
dronabinol 448
DUAVEE 449
DUETACT 450
DULERA 451
duloxetine hcl oral capsule delayed release particles 20 mg 452
duloxetine hcl oral capsule delayed release particles 30 mg 453
duloxetine hcl oral capsule delayed release particles 40 mg 454
duloxetine hcl oral capsule delayed release particles 60 mg 455
DUOPA ENTERAL 456

DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML....457
DURAGESIC-100....458
DURAGESIC-12....460
DURAGESIC-25....462
DURAGESIC-50....464
DURAGESIC-75....466
DUROLANE INTRA-ARTICULAR....468
dutasteride oral....469
DUZALLO....470
DYANAVEL XR....471
DYSPORT....472
econazole nitrate external....473
EDARBI....474
EDARBYCLOR....475
EDURANT....476
EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 150 MG....477
EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG, 75 MG....478
EFFIENT....479
ELAPRASE....480
ELELYSO....481
ELESTRIN....482
eletriptan hydrobromide....483
ELIDEL....484
ELIGARD....486
ELIQUIS ORAL TABLET 2.5 MG....487
ELIQUIS ORAL TABLET 5 MG....488
ELIQUIS STARTER PACK....489
ELMIRON....490
ELOCON EXTERNAL CREAM....491
ELOCON EXTERNAL OINTMENT....491
ELOCTATE....492
EMBEDA ORAL CAPSULE EXTENDED RELEASE 100-4 MG, 50-2 MG, 60-2.4 MG, 80-3.2 MG....493
EMBEDA ORAL CAPSULE EXTENDED RELEASE 20-0.8 MG, 30-1.2 MG....495
EMEND ORAL CAPSULE 125 MG, 40 MG, 80 MG....497
EMGALITY....498
EMSAM....499
EMTRIVA ORAL CAPSULE....500
EMVERM....501
ENABLEX....502
ENBREL MINI....505
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML....503
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML....504
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR....506
ENDARI....507
ENDOCET ORAL TABLET 10-325 MG....508
ENDOCET ORAL TABLET 2.5-325 MG, 5-325 MG....510
ENDOCET ORAL TABLET 7.5-325 MG....512
enoxaparin sodium....514
ENSTILAR....515
entecavir....516
ENTRESTO....517
ENTYVIO....518
EPANED ORAL SOLUTION....519
EPCLUSA....520
EPIDIOLEX....521
epinephrine injection solution auto-injector....522
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR....523
EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR....524
EPISNAP....525

EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML 526
epoprostenol sodium 527
eprosartan mesylate 528
ERIVEDGE 529
ERLEADA 530
ESBRIET ORAL CAPSULE 531
ESBRIET ORAL TABLET 267 MG 532
ESBRIET ORAL TABLET 801 MG 533
escitalopram oxalate oral tablet 10 mg 534
escitalopram oxalate oral tablet 20 mg, 5 mg 535
esomeprazole magnesium 536
estradiol transdermal patch twice weekly 537
estradiol transdermal patch weekly 538
estradiol-norethindrone acet oral tablet 0.5-0.1 mg 539
estradiol-norethindrone acet oral tablet 1-0.5 mg 540
ESTROGEL 541
eszopiclone 542
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 543
EVAMIST 544
EVEKEO 545
EVOXAC 546
EXALGO ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 547
EXELON TRANSDERMAL 549
EXFORGE 550
EXFORGE HCT 551
EXJADE 552
EXTAVIA SUBCUTANEOUS KIT 553
EYLEA INTRAVITREAL 554
ezetimibe 555
ezetimibe-simvastatin 556
FABIOR 557
FABRAZYME 558
famciclovir oral 559
FANAPT 560
FANAPT TITRATION PACK 561
FARXIGA 562
FARYDAK 563
FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML 564
FAZACLO ORAL TABLET DISPERSIBLE 100 MG 565
FAZACLO ORAL TABLET DISPERSIBLE 12.5 MG 566
FAZACLO ORAL TABLET DISPERSIBLE 150 MG 567
FAZACLO ORAL TABLET DISPERSIBLE 200 MG 568
FAZACLO ORAL TABLET DISPERSIBLE 25 MG 569
FEIBA 570
felodipine er 571
FEMRING 572
fenofibrate micronized 575
fenofibrate oral capsule 150 mg, 50 mg 573
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg 574
fenofibric acid oral capsule delayed release 576
fenofibric acid oral tablet 577
fentanyl 578
fentanyl citrate buccal 580
FENTORA BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG 582
FERRIPROX 584
FETZIMA 585
FETZIMA TITRATION 587
FIBRICOR 589
FIBRYGA 590
finasteride oral tablet 5 mg 591
FIORICET/CODEINE ORAL CAPSULE 50-300-40-30 MG 592
FIORINAL/CODEINE #3 594
FIRAZYR 596
FIRMAGON 597
FLEBOGAMMA DIF 598

FLOLAN 599
FLOVENT DISKUS 600
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT 601
FLOVENT HFA INHALATION AEROSOL 220 MCG/ACT 602
fluocinolone acetonide external cream 603
fluocinolone acetonide external ointment 604
fluocinonide external cream 605
fluocinonide external cream 606
fluocinonide external gel 606
fluocinonide external ointment 606
fluocinonide external solution 607
fluoxetine hcl oral capsule 10 mg 608
fluoxetine hcl oral capsule 20 mg 609
fluoxetine hcl oral capsule 40 mg 610
fluoxetine hcl oral capsule delayed release 611
fluoxetine hcl oral tablet 10 mg 612
fluoxetine hcl oral tablet 20 mg 613
fluoxetine hcl oral tablet 60 mg 614
flurandrenolide external cream 615
flurandrenolide external lotion 616
flurandrenolide external ointment 615
fluticasone propionate external cream 617
fluticasone-salmeterol 618
fluvastatin sodium 619
fluvastatin sodium er 620
fluvoxamine maleate er 623
fluvoxamine maleate oral tablet 100 mg 621
fluvoxamine maleate oral tablet 25 mg, 50 mg 622
FOCALIN 624
FOCALIN XR 625
fondaparinux sodium 626
FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML 627
FOSAMAX ORAL TABLET 70 MG 628
FOSAMAX PLUS D 629
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML, 95000 UNIT/3.8ML 630
FREESTYLE INSULINX TEST 631
FREESTYLE LITE TEST 632
FREESTYLE PRECISION NEO TEST 633
FREESTYLE TEST 634
FROVA 635
frovatriptan succinate 636
FULPHILA 637
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 638
FYCOMPA ORAL TABLET 639
gabapentin oral capsule 640
gabapentin oral tablet 641
GABITRIL ORAL TABLET 12 MG, 4 MG 642
GABITRIL ORAL TABLET 16 MG 643
GABITRIL ORAL TABLET 2 MG 644
GALAFOLD 645
galantamine hydrobromide 646
galantamine hydrobromide er 647
GAMMAGARD 648
GAMMAGARD S/D LESS IGA 649
GAMMAKED 650
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/200ML, 20 GM/400ML, 5 GM/100ML 651
GAMUNEX-C 652
GATTEX 653
GELNIQUE TRANSDERMAL GEL 10 % 654
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE 655
GELSYN-3 656
GENOTROPIN 657
GENOTROPIN MINIQUICK 658
GENVOYA 659

GEODON ORAL....660
GILENYA ORAL CAPSULE 0.25 MG 661
GILENYA ORAL CAPSULE 0.5 MG.662
GILOTRIF....663
GLASSIA....664
glatiramer acetate....665
GLATOPA....666
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG....667
GLUCAGEN HYPOKIT.... 669
GLUCAGON EMERGENCY.... 670
GLYXAMBI.... 671
GRALISE ORAL TABLET 300 MG....672
GRALISE ORAL TABLET 600 MG....673
GRALISE STARTER....674
GRANIX....675
guanfacine hcl er....676
HAEGARDA....677
halobetasol propionate.... 678
HARVONI.... 679
HELIXATE FS.... 680
HEMANGEOL....681
HEMLIBRA....682
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT....683
HEPSERA....684
HETLIOZ....685
HIZENTRA SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML.686
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG..... 687
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG..... 688
HP ACTHAR....689
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 500-1200 UNIT....690
HUMATROPE.... 691
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML.... 696
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML.... 697
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML..... 698
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML...699
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML...700
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML....701
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML....702
HUMIRA PEN-PS/UV STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML....703
HUMIRA PEN-PS/UV STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML.....704
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML..... 692
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML..... 693
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML..... 694
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML..... 695
HYALGAN....705
HYCAMTIN ORAL....706

hydrocod polst-cpm polst er oral suspension extended release.....707
hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml.....708
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg.....710
hydrocodone-acetaminophen oral tablet 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg.....712
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg.....714
hydromorphone hcl er.....726
hydromorphone hcl oral liquid.....716
hydromorphone hcl oral tablet 2 mg.....718
hydromorphone hcl oral tablet 4 mg.....720
hydromorphone hcl oral tablet 8 mg.....722
hydromorphone hcl rectal.....724
hydroxyprogesterone caproate intramuscular oil.....728
HYMOVIS.....729
HYQVIA.....730
HYSINGLA ER.....731
HYZAAR.....733
ibandronate sodium oral.....734
IBRANCE.....735
IBUDONE ORAL TABLET 10-200 MG.....736
ibudone oral tablet 5-200 mg.....736
ICLUSIG ORAL TABLET 15 MG.....738
ICLUSIG ORAL TABLET 45 MG.....739
IDELVION.....740
IDHIFA.....741
ILARIS SUBCUTANEOUS SOLUTION.....742
ILUMYA.....743
imatinib mesylate oral tablet 100 mg.....744
imatinib mesylate oral tablet 400 mg.....745
IMBRUVICA ORAL CAPSULE 70 MG.....746
IMBRUVICA ORAL TABLET.....747
imiquimod external.....748
imiquimod pump.....749
IMITREX NASAL.....750
IMITREX ORAL.....751
IMITREX STATDOSE REFILL SUBCUTANEOUS SOLUTION CARTRIDGE.....753
IMITREX STATDOSE SYSTEM SUBCUTANEOUS SOLUTION AUTO-INJECTOR.....754
IMITREX SUBCUTANEOUS.....752
IMPAVIDO.....755
IMVEXXY MAINTENANCE PACK..756
IMVEXXY STARTER PACK.....757
INCRELEX.....758
INCRUSE ELLIPTA.....759
INDERAL XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 80 MG.....760
indomethacin oral.....761
INFLECTRA.....762
INGREZZA ORAL CAPSULE 40 MG763
INGREZZA ORAL CAPSULE 80 MG764
INLYTA.....765
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG.....766
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 80 MG.....767
INTELENCE ORAL TABLET 100 MG, 25 MG.....768
INTELENCE ORAL TABLET 200 MG 769
INTRAROSA.....770
INTRON A.....771
INTUNIV.....772
INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 1.5 MG, 3 MG, 6 MG.....773
INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG.....774

INVOKAMET 775
INVOKAMET XR 776
INVOKANA 777
ipratropium bromide nasal 778
irbesartan 779
irbesartan-hydrochlorothiazide 780
IRESSA 781
ISENTRESS HD 784
ISENTRESS ORAL TABLET 782
ISENTRESS ORAL TABLET CHEWABLE 783
isotretinoin oral 785
itraconazole oral capsule 786
IXINITY 787
JADENU 788
JADENU SPRINKLE 789
JAKAFI ORAL TABLET 10 MG 790
JAKAFI ORAL TABLET 15 MG, 20 MG, 25 MG, 5 MG 791
JANUMET 792
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-500 MG 793
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG 794
JANUVIA 795
JARDIANCE 796
JENTADUETO 797
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG 798
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG 799
JETREA INTRAVITREAL SOLUTION 0.375 MG/0.3ML 800
JIVI 801
JUBLIA 802
JULUCA 803
JUXTAPID 804
JYNARQUE 805
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 806
KALBITOR 808
KALYDECO ORAL PACKET 809
KALYDECO ORAL TABLET 810
KANUMA 811
KAPVAY ORAL TABLET EXTENDED RELEASE 12 HOUR 812
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 813
KCENTRA 814
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG 815
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 750 MG 816
KERYDIN 817
ketoconazole oral 818
ketorolac tromethamine oral 819
KEVEYIS 820
KEVZARA 821
KHEDEZLA 822
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 824
KISQALI 200 DOSE 825
KISQALI 400 DOSE 826
KISQALI 600 DOSE 827
KISQALI FEMARA 200 DOSE 828
KISQALI FEMARA 400 DOSE 829
KISQALI FEMARA 600 DOSE 830
KLOR-CON ORAL PACKET 20 MEQ 831
KOATE 832
KOATE-DVI 833
KOGENATE FS 834
KORLYM 835
KOVALTRY 836
KRISTALOSE 837
KRYSTEXXA 838

KUVAN 839
KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE . 840
lactulose oral packet 841
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG 842
LAMICTAL ODT ORAL TABLET DISPERSIBLE 200 MG 843
LAMICTAL ODT ORAL TABLET DISPERSIBLE 25 MG 844
LAMICTAL ODT ORAL TABLET DISPERSIBLE 50 MG 845
LAMICTAL XR ORAL KIT 846
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 25 MG, 50 MG 847
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 200 MG 848
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG 849
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG 850
lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg 854
lamotrigine er oral tablet extended release 24 hour 200 mg 855
lamotrigine er oral tablet extended release 24 hour 250 mg, 300 mg 856
lamotrigine oral tablet dispersible 100 mg, 200 mg 851
lamotrigine oral tablet dispersible 25 mg . 852
lamotrigine oral tablet dispersible 50 mg . 853
lansoprazole oral capsule delayed release 15 mg 857
lansoprazole oral capsule delayed release 30 mg 858
lansoprazole oral tablet dispersible 859
LATUDA ORAL TABLET 120 MG, 40 MG 860
LATUDA ORAL TABLET 20 MG 861
LATUDA ORAL TABLET 60 MG 862
LATUDA ORAL TABLET 80 MG 863
leflunomide oral 864
LEMTRADA 865
LENVIMA 10 MG DAILY DOSE 866
LENVIMA 12 MG DAILY DOSE 867
LENVIMA 14 MG DAILY DOSE 868
LENVIMA 18 MG DAILY DOSE 869
LENVIMA 20 MG DAILY DOSE 870
LENVIMA 24 MG DAILY DOSE 871
LENVIMA 4 MG DAILY DOSE 872
LENVIMA 8 MG DAILY DOSE 873
LESCOL ORAL CAPSULE 20 MG 874
LESCOL XL 875
LETAIRIS 876
LEUKINE INTRAVENOUS 877
leuprolide acetate injection 878
levetiracetam er oral tablet extended release 24 hour 500 mg 879
levetiracetam er oral tablet extended release 24 hour 750 mg 880
levorphanol tartrate oral 881
LEVULAN KERASTICK 883
LEXAPRO ORAL TABLET 10 MG 884
LEXAPRO ORAL TABLET 20 MG, 5 MG 885
LIALDA 886
lidocaine external ointment 887
lidocaine external patch 5 % 889
lidocaine pak 890
lidocaine-prilocaine external cream 892
lidocaine-tetracaine 894
LIDODERM 895
linezolid oral suspension reconstituted 896
linezolid oral tablet 897
LINZESS ORAL CAPSULE 145 MCG, 290 MCG 898
LIPITOR 899
LIPOFEN 900
LIVALO 901
LOKELMA 902

LONHALA MAGNAIR REFILL KIT 903
LONHALA MAGNAIR STARTER KIT 904
LONSURF ORAL TABLET 15-6.14 MG 905
LONSURF ORAL TABLET 20-8.19 MG 906
LORCET 907
LORCET HD 909
LORCET PLUS ORAL TABLET 7.5-325 MG 911
LORTAB ORAL ELIXIR 10-300 MG/15ML 913
losartan potassium oral tablet 25 mg, 50 mg 915
LOTRONEX 916
lovastatin 917
LOVAZA 918
LOVENOX 919
LUCEMYRA 920
LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE. 921
LUMIGAN OPHTHALMIC SOLUTION 0.01 % 922
LUMIZYME 923
LUNESTA 924
LUPANETA PACK 925
LUPRON DEPOT (1-MONTH) 926
LUPRON DEPOT (3-MONTH) 927
LUPRON DEPOT (4-MONTH) 928
LUPRON DEPOT (6-MONTH) 929
LUPRON DEPOT-PED (1-MONTH) .. 930
LUPRON DEPOT-PED (3-MONTH) .. 931
LYNPARZA ORAL TABLET 932
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 165 MG, 82.5 MG 933
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 330 MG 934
LYSTEDA 935
MACUGEN 936
MAKENA SUBCUTANEOUS 937
maprotiline hcl oral tablet 25 mg 938
maprotiline hcl oral tablet 50 mg 939
maprotiline hcl oral tablet 75 mg 940
MARINOL 941
MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 180 MG, 300 MG, 360 MG 942
MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 240 MG 943
MAVYRET 944
MAXALT ORAL TABLET 10 MG 945
MAXALT-MLT 946
mefenamic acid oral 947
MEKINIST ORAL TABLET 0.5 MG .. 948
MEKINIST ORAL TABLET 2 MG 949
MEKTOVI 950
memantine hcl er 952
memantine hcl oral tablet 951
MENOSTAR 953
meperidine hcl oral solution 954
meperidine hcl oral tablet 100 mg 956
meperidine hcl oral tablet 50 mg 958
MEPHYTON 960
mesalamine oral tablet delayed release 1.2 gm 961
mesalamine oral tablet delayed release 800 mg 962
METADATE ER ORAL TABLET EXTENDED RELEASE 20 MG 963
METHADONE HCL INTENSOL 979
methadone hcl oral concentrate 964
methadone hcl oral solution 10 mg/5ml 967
methadone hcl oral solution 5 mg/5ml 970
methadone hcl oral tablet 10 mg 973
methadone hcl oral tablet 5 mg 976
METHADOSE ORAL CONCENTRATE 10 MG/ML 982
METHADOSE SUGAR-FREE 985
methamphetamine hcl 988
METHERGINE ORAL 989

METHYLIN ORAL SOLUTION 10 MG/5ML 990
METHYLIN ORAL SOLUTION 5 MG/5ML 991
methylphenidate hcl er (cd) 1003
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg 1004
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 40 mg .. 1005
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg 1006
methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg 1007
methylphenidate hcl er oral tablet extended release 10 mg 996
methylphenidate hcl er oral tablet extended release 18 mg, 27 mg, 54 mg 997
methylphenidate hcl er oral tablet extended release 20 mg 998
methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg 1001
methylphenidate hcl er oral tablet extended release 24 hour 36 mg 1002
methylphenidate hcl er oral tablet extended release 36 mg 999
methylphenidate hcl er oral tablet extended release 72 mg 1000
methylphenidate hcl oral solution 10 mg/5ml 992
methylphenidate hcl oral solution 5 mg/5ml 993
methylphenidate hcl oral tablet 994
methylphenidate hcl oral tablet chewable . 995
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 50 mg 1008
metoprolol succinate er oral tablet extended release 24 hour 200 mg 1009
metoprolol succinate er oral tablet extended release 24 hour 25 mg 1010
MEVACOR ORAL TABLET 40 MG . 1011
MIACALCIN NASAL 1012
MICARDIS 1013
MICARDIS HCT 1014
miglustat 1015
MIMVEY 1016
MIMVEY LO 1017
MINIVELLE 1018
MIRAPEX ER 1019
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 1020
mirtazapine oral tablet 1021
mirtazapine oral tablet dispersible 1022
MITIGARE 1023
modafinil 1024
mometasone furoate external cream 1026
mometasone furoate external ointment .. 1026
MONOCLATE-P INTRAVENOUS KIT 1000 UNIT 1027
MONONINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT 1028
MONOVISC 1029
montelukast sodium oral packet 1030
montelukast sodium oral tablet 1031
montelukast sodium oral tablet chewable 1031
MORPHABOND ER 1032
morphine sulfate (concentrate) oral solution 100 mg/5ml 1048
morphine sulfate er beads 1057
morphine sulfate er oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg 1050
morphine sulfate er oral capsule extended release 24 hour 40 mg 1052
morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg 1053
morphine sulfate er oral tablet extended release 15 mg, 30 mg 1055
morphine sulfate oral solution 10 mg/5ml 1034

morphine sulfate oral solution 20 mg/5ml 1036
morphine sulfate oral tablet 15 mg 1038
morphine sulfate oral tablet 30 mg 1040
morphine sulfate rectal suppository 10 mg, 5 mg 1042
morphine sulfate rectal suppository 20 mg 1044
morphine sulfate rectal suppository 30 mg 1046
MOVANTIK 1059
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 200 MG, 60 MG 1060
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG 1062
MULPLETA 1064
MULTAQ 1065
mupirocin calcium 1067
mupirocin external 1066
MYALEPT 1068
MYDAYIS 1069
myorisan oral capsule 10 mg, 20 mg, 40 mg 1070
MYORISAN ORAL CAPSULE 30 MG 1070
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG 1071
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 50 MG 1072
MYTESI 1073
NAGLAZYME 1074
NAMENDA ORAL TABLET 1075
NAMENDA TITRATION PAK 1076
NAMENDA XR 1077
NAMENDA XR TITRATION PACK 1078
NAMZARIC 1079
naratriptan hcl 1080
NARCAN 1081
NASACORT ALLERGY 24HR 1082
NASACORT ALLERGY 24HR CHILDREN 1083
nasal allergy 24 hour 1084
NASONEX 1085
NATPARA 1086
NERLYNX 1087
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1088
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML 1089
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 1090
NEUPRO 1091
NEURONTIN ORAL CAPSULE 1092
NEURONTIN ORAL TABLET 1093
nevirapine er oral tablet extended release 24 hour 100 mg 1094
nevirapine er oral tablet extended release 24 hour 400 mg 1095
NEXAVAR 1096
NEXIUM 24HR 1099
NEXIUM ORAL CAPSULE DELAYED RELEASE 40 MG 1097
NEXIUM ORAL PACKET 1098
nicotine 1100
nicotine polacrilex mouth/throat gum 1101
nicotine polacrilex mouth/throat lozenge 1102
NICOTROL 1103
NICOTROL NS 1104
NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG 1105
nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg 1106
nifedipine er oral tablet extended release 24 hour 60 mg 1107
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 90 mg .. 1108

nifedipine er osmotic release oral tablet extended release 24 hour 60 mg 1109
NINLARO 1110
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 34 mg, 40 mg, 8.5 mg 1111
nisoldipine er oral tablet extended release 24 hour 30 mg 1112
NITROSTAT 1113
NITYR 1114
NIVESTYM 1115
NOCDURNA 1116
NOCTIVA 1119
NOLIX EXTERNAL LOTION 1120
NORCO ORAL TABLET 10-325 MG 1121
NORCO ORAL TABLET 5-325 MG, 7.5-325 MG 1123
NORDITROPIN FLEXPRO 1125
NORTHERA ORAL CAPSULE 100 MG, 200 MG 1126
NORTHERA ORAL CAPSULE 300 MG 1127
NOVOEIGHT 1128
NOVOSEVEN RT 1129
NOXAFIL ORAL TABLET DELAYED RELEASE 1130
NPLATE 1131
NUCALA 1132
NUCYNTA ER 1139
NUCYNTA ORAL TABLET 100 MG 1133
NUCYNTA ORAL TABLET 50 MG. 1135
NUCYNTA ORAL TABLET 75 MG. 1137
NUEDEXTA 1141
NUPLAZID ORAL CAPSULE 1142
NUPLAZID ORAL TABLET 10 MG 1143
NUPLAZID ORAL TABLET 17 MG 1144
NUTROPIN AQ NUSPIN 10 1145
NUTROPIN AQ NUSPIN 20 1146
NUTROPIN AQ NUSPIN 5 1147
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG 1148
NUVIGIL ORAL TABLET 50 MG 1150
NUWIQ 1152
NYMALIZE ORAL SOLUTION 60 MG/20ML 1153
OCALIVA ORAL TABLET 5 MG 1154
OCTAGAM 1155
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml 1156
ODEFSEY 1157
ODOMZO 1158
OFEV 1159
ofloxacin oral tablet 300 mg 1160
olanzapine oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg 1161
olanzapine oral tablet 2.5 mg 1162
olanzapine oral tablet dispersible 10 mg . 1163
olanzapine oral tablet dispersible 15 mg, 20 mg, 5 mg 1161
olanzapine-fluoxetine hcl oral capsule 12-25 mg 1164
olanzapine-fluoxetine hcl oral capsule 12-50 mg, 6-25 mg, 6-50 mg 1165
olmesartan medoxomil oral 1166
olmesartan medoxomil-hctz 1167
olmesartan-amlodipine-hctz 1168
OLUMIANT 1169
OLUX 1170
OLUX-E 1171
omega-3-acid ethyl esters 1172
omeprazole-sodium bicarbonate oral capsule 20-1100 mg 1173
OMNARIS 1174
OMNITROPE 1175
ONETOUCH ULTRA BLUE 1176
ONETOUCH VERIO IN VITRO STRIP 1177
ONFI ORAL SUSPENSION 1178
ONFI ORAL TABLET 10 MG, 20 MG 1179
ONZETRA XSAIL 1180
OPANA ORAL TABLET 10 MG 1181

OPANA ORAL TABLET 5 MG.....1183
OPSUMIT..... 1185
ORAVIG..... 1186
ORENCIA CLICKJECT..... 1190
ORENCIA INTRAVENOUS..... 1187
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML.....1188
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML, 87.5 MG/0.7ML.....1189
ORENITRAM.....1191
ORFADIN..... 1192
ORILISSA ORAL TABLET 150 MG. 1193
ORILISSA ORAL TABLET 200 MG. 1194
ORKAMBI ORAL PACKET..... 1195
ORKAMBI ORAL TABLET 100-125 MG..... 1196
ORKAMBI ORAL TABLET 200-125 MG..... 1197
ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE1198
oseltamivir phosphate oral capsule.....1199
oseltamivir phosphate oral suspension reconstituted..... 1200
OSPHENA..... 1201
OTEZLA ORAL TABLET..... 1202
OTEZLA ORAL TABLET THERAPY PACK..... 1203
OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 17.5 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML..... 1204
OXAYDO ORAL TABLET ABUSE-DETERRENT 5 MG..... 1205
OXAYDO ORAL TABLET ABUSE-DETERRENT 7.5 MG.....1207
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG..... 1209
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 600 MG..... 1210
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg..1212
oxybutynin chloride er oral tablet extended release 24 hour 5 mg.....1213
oxybutynin chloride oral tablet.....1211
oxycodone hcl er oral tablet er 12 hour abuse-deterrent..... 1228
oxycodone hcl oral capsule..... 1214
oxycodone hcl oral concentrate 100 mg/5ml.....1216
oxycodone hcl oral solution..... 1218
oxycodone hcl oral tablet 10 mg, 5 mg...1220
oxycodone hcl oral tablet 15 mg..... 1222
oxycodone hcl oral tablet 20 mg..... 1224
oxycodone hcl oral tablet 30 mg..... 1226
oxycodone-acetaminophen oral tablet 10-325 mg.....1230
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg.....1232
oxycodone-acetaminophen oral tablet 7.5-325 mg.....1234
oxycodone-aspirin oral tablet 4.8355-325 mg..... 1236
oxycodone-ibuprofen.....1238
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT..... 1240
oxymorphone hcl er.....1246
oxymorphone hcl oral tablet 10 mg.....1242
oxymorphone hcl oral tablet 5 mg.....1244
OXYTROL FOR WOMEN..... 1248
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg.....1249
paliperidone er oral tablet extended release 24 hour 9 mg.....1250
PALYNZIQ.....1251
PANCREAZE..... 1252
PANZYGA.....1253
paricalcitol oral.....1254
paroxetine hcl er..... 1257

paroxetine hcl oral tablet 10 mg, 20 mg . 1255
paroxetine hcl oral tablet 30 mg, 40 mg . 1256
paroxetine mesylate 1258
PAXIL CR 1262
PAXIL ORAL SUSPENSION 1259
PAXIL ORAL TABLET 10 MG, 20 MG 1260
PAXIL ORAL TABLET 30 MG, 40 MG 1261
PEGASYS PROCLICK 1264
PEGASYS SUBCUTANEOUS SOLUTION 1263
PENLAC 1265
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG 1266
PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG 1267
pentazocine-naloxone hcl 1268
PERCOCET ORAL TABLET 10-325 MG 1270
PERCOCET ORAL TABLET 2.5-325 MG, 5-325 MG 1272
PERCOCET ORAL TABLET 7.5-325 MG 1274
PERFOROMIST 1276
PERTZYE 1277
phenoxybenzamine hcl oral 1278
phytonadione oral 1279
PICATO 1280
pioglitazone hcl 1281
pioglitazone hcl-glimepiride 1282
pioglitazone hcl-metformin hcl 1283
PLAVIX ORAL TABLET 300 MG 1284
PLAVIX ORAL TABLET 75 MG 1285
PLEGRIDY 1286
PLEGRIDY STARTER PACK 1287
POMALYST 1288
PONSTEL 1289
potassium chloride oral packet 1290
PRADAXA 1291
PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 1292
pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 3 mg, 3.75 mg, 4.5 mg 1293
pramipexole dihydrochloride er oral tablet extended release 24 hour 2.25 mg 1294
prasugrel hcl 1295
PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG 1296
pravastatin sodium 1297
PRECISION PCX 1298
PRECISION PCX PLUS TEST 1299
PRECISION POINT OF CARE TEST 1300
PRECISION QID TEST 1301
PRECISION SOF-TACT TEST 1302
PRECISION XTRA BLOOD GLUCOSE 1303
PREFEST 1304
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG 1305
PREVACID 24HR 1307
PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG 1306
PREVACID SOLUTAB 1308
PREVYMIS ORAL 1310
PREZISTA ORAL SUSPENSION 1311
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG 1312
PREZISTA ORAL TABLET 800 MG 1313
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 50 MG 1314
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG 1316
PRIVIGEN 1318
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 90 MG 1319
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG 1320

PROCENTRA....1321
PROCRIT....1322
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG....1323
PROCYSBI ORAL CAPSULE DELAYED RELEASE 75 MG....1324
PROFILNINE SD....1325
PROLASTIN-C INTRAVENOUS SOLUTION....1326
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG....1326
PROLIA....1327
PROMACTA....1328
PROMETRIUM....1329
propafenone hcl er....1330
PROSCAR....1331
PROTONIX ORAL....1332
PROTOPIC....1333
PROVENTIL HFA....1335
PROVIGIL....1336
PROZAC ORAL CAPSULE 10 MG....1338
PROZAC ORAL CAPSULE 20 MG....1339
PROZAC ORAL CAPSULE 40 MG....1340
PRUDOXIN....1341
psorcon....1342
PULMICORT....1343
PULMICORT FLEXHALER....1344
PULMOZYME....1345
PURIXAN....1346
QBRELIS....1347
QBREXZA....1348
QNASL....1349
QNASL CHILDRENS....1350
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 25 MG, 50 MG....1351
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 150 MG, 200 MG....1352
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg....1357
quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg....1358
quetiapine fumarate er oral tablet extended release 24 hour 50 mg....1359
quetiapine fumarate oral tablet 100 mg, 50 mg....1353
quetiapine fumarate oral tablet 200 mg....1354
quetiapine fumarate oral tablet 25 mg....1355
quetiapine fumarate oral tablet 300 mg, 400 mg....1356
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 40 MG....1360
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 30 MG....1361
QUILLIVANT XR....1362
QVAR REDIHALER....1363
rabeprazole sodium....1364
RANEXA....1365
rasagiline mesylate oral....1366
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML....1367
RAVICTI....1368
RAYALDEE....1369
RAZADYNE ER....1371
RAZADYNE ORAL TABLET....1370
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR....1373
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR....1374

REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1372
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1375
REBINYN 1376
RECOMBINATE 1377
RECTIV 1378
REGRANEX 1379
RELENZA DISKHALER 1380
RELEXXII 1381
RELISTOR ORAL 1382
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML 1383
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML 1384
RELPAX 1385
REMERON ORAL TABLET 15 MG, 30 MG 1386
REMERON SOLTAB 1387
REMICADE 1388
REMODULIN 1389
RENFLEXIS 1390
repaglinide-metformin hcl 1391
REPATHA 1392
REPATHA PUSHTRONEX SYSTEM 1393
REPATHA SURECLICK 1394
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG 1395
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HOUR 2 MG, 4 MG, 6 MG, 8 MG 1396
RESTORIL ORAL CAPSULE 22.5 MG, 7.5 MG 1397
RETACRIT 1398
RETIN-A 1399
RETIN-A MICRO 1401
RETIN-A MICRO PUMP 1403
REVATIO INTRAVENOUS 1405
REVATIO ORAL SUSPENSION RECONSTITUTED 1406
REVATIO ORAL TABLET 1407
REVLIMID 1408
REXULTI 1409
REYATAZ ORAL CAPSULE 150 MG 1411
REYATAZ ORAL CAPSULE 200 MG 1412
REYATAZ ORAL CAPSULE 300 MG 1413
RHOFADE 1414
RHOPRESSA 1415
RIASTAP 1416
RILUTEK 1417
riluzole 1418
risedronate sodium oral tablet 150 mg 1419
risedronate sodium oral tablet 30 mg, 5 mg 1420
risedronate sodium oral tablet 35 mg 1421
risedronate sodium oral tablet delayed release 1422
RISPERDAL ORAL SOLUTION 1423
RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG 1424
RISPERDAL ORAL TABLET 3 MG 1426
RISPERDAL ORAL TABLET 4 MG 1428
RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 0.5 MG, 1 MG, 2 MG 1433
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg 1430
risperidone oral tablet 3 mg 1431
risperidone oral tablet 4 mg 1432
risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg 1430
risperidone oral tablet dispersible 3 mg 1431
risperidone oral tablet dispersible 4 mg 1432
RITALIN 1434
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 40 MG 1435

RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 30 MG 1436
rivastigmine 1437
rivastigmine tartrate 1438
RIXUBIS 1439
rizatriptan benzoate 1440
ropinirole hcl er oral tablet extended release 24 hour 12 mg 1441
ropinirole hcl er oral tablet extended release 24 hour 2 mg, 4 mg, 6 mg, 8 mg . 1442
rosuvastatin calcium 1443
ROXICODONE ORAL TABLET 15 MG 1444
ROXICODONE ORAL TABLET 30 MG 1446
ROXICODONE ORAL TABLET 5 MG 1448
ROXYBOND ORAL TABLET ABUSE-DETERRENT 15 MG 1450
ROXYBOND ORAL TABLET ABUSE-DETERRENT 30 MG 1452
ROXYBOND ORAL TABLET ABUSE-DETERRENT 5 MG 1454
ROZEREM 1456
RUBRACA ORAL TABLET 200 MG, 300 MG 1457
RUBRACA ORAL TABLET 250 MG 1458
RUCONEST 1459
RYDAPT 1460
RYTHMOL SR 1461
SABRIL 1462
SAIZEN 1463
SAMSCA ORAL TABLET 15 MG 1464
SAMSCA ORAL TABLET 30 MG 1465
SANCUSO 1466
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML 1467
SANDOSTATIN LAR DEPOT 1468
SANTYL 1469
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG 1470
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 2.5 MG 1471
SAVAYSA 1472
SAVELLA 1473
SAVELLA TITRATION PACK 1474
SEEBRI NEOHALER 1475
SELZENTRY ORAL SOLUTION 1476
SELZENTRY ORAL TABLET 150 MG 1477
SELZENTRY ORAL TABLET 25 MG 1478
SELZENTRY ORAL TABLET 75 MG 1479
SENSIPAR 1480
SEREVENT DISKUS 1481
SEROQUEL ORAL TABLET 100 MG, 50 MG 1482
SEROQUEL ORAL TABLET 200 MG 1484
SEROQUEL ORAL TABLET 25 MG 1486
SEROQUEL ORAL TABLET 300 MG 1488
SEROQUEL ORAL TABLET 400 MG 1490
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG 1492
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG, 400 MG 1493
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50 MG 1494
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG 1495
sertraline hcl oral tablet 100 mg 1496
sertraline hcl oral tablet 25 mg 1497
sertraline hcl oral tablet 50 mg 1498
SIGNIFOR 1499

SIGNIFOR LAR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 1500
SIKLOS 1501
sildenafil citrate oral tablet 20 mg 1502
SILIQ 1503
SIMPONI ARIA 1505
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1504
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1504
simvastatin oral 1506
SINGULAIR ORAL PACKET 1507
SINGULAIR ORAL TABLET 1508
SINGULAIR ORAL TABLET CHEWABLE 1509
SIRTURO 1510
SIVEXTRO ORAL 1511
sodium phenylbutyrate oral powder 3 gm/tsp 1512
sodium phenylbutyrate oral tablet 1513
SOLIQUA 1514
SOMATULINE DEPOT 1515
SOMAVERT 1516
SOOLANTRA 1517
SORIATANE ORAL CAPSULE 10 MG 1518
SORIATANE ORAL CAPSULE 25 MG 1519
SOVALDI 1520
SPIRIVA HANDIHALER 1521
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT 1522
SPORANOX ORAL CAPSULE 1523
SPORANOX PULSEPAK 1524
SPRITAM 1525
SPRYCEL ORAL TABLET 100 MG, 140 MG 1526
SPRYCEL ORAL TABLET 20 MG, 50 MG, 70 MG, 80 MG 1527
STELARA INTRAVENOUS 1528
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML 1529
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1530
STIMATE 1531
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT 1532
STIVARGA 1533
STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG, 60 MG. 1534
STRATTERA ORAL CAPSULE 100 MG, 80 MG 1535
STRENSIQ 1536
STRIBILD 1537
STRIVERDI RESPIMAT 1538
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG 1539
SUBOXONE SUBLINGUAL FILM 8-2 MG 1540
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG 1541
sulfasalazine oral tablet 1542
sulfasalazine oral tablet delayed release 1543
SULFAZINE 1544
sumatriptan nasal 1545
sumatriptan succinate oral 1546
sumatriptan succinate refill subcutaneous solution cartridge 1550
sumatriptan succinate subcutaneous solution 6 mg/0.5ml 1547
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml 1548
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml 1549
SUPPRELIN LA 1551
SUTENT ORAL CAPSULE 12.5 MG 1552
SUTENT ORAL CAPSULE 25 MG ... 1553
SUTENT ORAL CAPSULE 37.5 MG 1554
SUTENT ORAL CAPSULE 50 MG ... 1555

SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG 1556
SYMBICORT 1557
SYMBYAX ORAL CAPSULE 12-25 MG, 12-50 MG, 6-25 MG, 6-50 MG ... 1558
SYMDEKO 1559
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1560
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1562
SYMPROIC 1563
SYMTUZA 1564
SYNAGIS 1565
SYNALAR EXTERNAL CREAM 1566
SYNALAR EXTERNAL OINTMENT 1567
SYNAREL 1568
SYNDROS 1569
SYNERA 1570
SYNJARDY 1571
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG . 1572
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG 1573
SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 1574
SYNVISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 1575
SYPRINE 1576
TACLONEX EXTERNAL SUSPENSION 1577
tacrolimus external 1578
tadalafil (pah) 1582
tadalafil oral tablet 2.5 mg, 5 mg 1580
TAFINLAR 1583
TAGRISSO 1584
TAKHZYRO 1585
TALTZ 1586
TALZENNA ORAL CAPSULE 0.25 MG 1587
TALZENNA ORAL CAPSULE 1 MG 1588
TAMIFLU ORAL CAPSULE 1589
TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML 1590
TARCEVA 1591
TARGRETIN ORAL 1592
TASIGNA ORAL CAPSULE 150 MG, 200 MG 1593
TASIGNA ORAL CAPSULE 50 MG 1594
TAVALISSE 1595
tazarotene external 1596
TAZORAC 1597
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG, 360 MG 1598
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG 1599
TECFIDERA 1600
TECHNIVIE 1601
TEKTURNA 1602
TEKTURNA HCT 1603
telmisartan 1604
telmisartan-amlodipine 1605
telmisartan-hctz 1606
temazepam oral capsule 22.5 mg, 7.5 mg 1607
TEMOVATE EXTERNAL CREAM . 1608
TEMOVATE EXTERNAL OINTMENT 1608
temozolomide 1609
tenofovir disoproxil fumarate 1610
testosterone transdermal gel 10 mg/act (2%) 1611
testosterone transdermal gel 12.5 mg/act (1%), 50 mg/5gm (1%) 1613
testosterone transdermal gel 20.25 mg/1.25gm (1.62%) 1615
testosterone transdermal gel 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%) 1616

testosterone transdermal gel 25 mg/2.5gm (1%) 1617
testosterone transdermal solution 1619
tetrabenazine oral tablet 12.5 mg 1621
tetrabenazine oral tablet 25 mg 1622
THALOMID 1623
THIOLA 1624
tiagabine hcl oral tablet 12 mg 1625
tiagabine hcl oral tablet 16 mg 1626
tiagabine hcl oral tablet 2 mg 1627
tiagabine hcl oral tablet 4 mg 1628
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG, 360 MG, 420 MG 1629
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG 1630
TIBSOVO 1631
TIGLUTIK 1632
TIVICAY ORAL TABLET 10 MG, 25 MG 1633
TIVICAY ORAL TABLET 50 MG 1634
TOBI 1635
TOBI PODHALER 1636
tobramycin inhalation 1637
tolterodine tartrate er 1638
TOPAMAX SPRINKLE 1639
TOPICORT EXTERNAL CREAM 1640
TOPICORT EXTERNAL GEL 1640
TOPICORT EXTERNAL OINTMENT 1640
topiramate oral capsule sprinkle 1641
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 50 MG 1642
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 200 MG 1643
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG 1644
TOVIAZ 1645
TRACLEER 1646
TRADJENTA 1647
tramadol hcl er (biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg 1652
tramadol hcl er oral tablet extended release 24 hour 1650
tramadol hcl oral 1648
tramadol-acetaminophen 1654
tranexamic acid oral 1656
TRELEGY ELLIPTA 1657
TRELSTAR MIXJECT 1658
TREMFYA 1659
tretinoin external 1660
tretinoin microsphere 1661
tretinoin microsphere pump 1662
TRETTEN 1663
TREZIX ORAL CAPSULE 320.5-30-16 MG 1664
triamcinolone acetonide nasal aerosol 1666
TRIBENZOR 1667
TRICOR 1668
TRIDESILON 1669
trientine hcl 1670
TRIGLIDE ORAL TABLET 160 MG 1671
TRILIPIX 1672
TRINTELLIX 1673
TRIPTODUR 1675
TRIUMEQ 1676
TRIVISC 1677
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 25 MG, 50 MG 1678
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG 1679
trospium chloride 1680
trospium chloride er 1681
TRULANCE 1682
TRULICITY 1683

TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 1684
TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 10-8 MG 1685
TUSSIONEX PENNKINETIC ER ORAL SUSPENSION EXTENDED RELEASE 1686
TWYNSTA 1687
TYBOST 1688
TYKERB 1689
TYLENOL WITH CODEINE #3 1690
TYLENOL WITH CODEINE #4 1692
TYMLOS 1694
TYSABRI 1695
TYVASO 1696
TYVASO REFILL 1697
TYVASO STARTER 1698
UCERIS ORAL 1699
UCERIS RECTAL 1700
ULESFIA 1701
ULORIC 1702
ULTRACET 1703
ULTRAM 1705
ULTRAVATE EXTERNAL CREAM 1707
ULTRAVATE EXTERNAL LOTION 1708
ULTRAVATE EXTERNAL OINTMENT 1707
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG 1709
UPTRAVI ORAL TABLET 200 MCG 1710
UPTRAVI ORAL TABLET THERAPY PACK 1710
UROXATRAL 1711
UTIBRON NEOHALER 1712
VALCHLOR 1713
VALCYTE ORAL SOLUTION RECONSTITUTED 1714
VALCYTE ORAL TABLET 1715
valganciclovir hcl oral solution reconstituted 1716
valganciclovir hcl oral tablet 1717
valsartan 1718
valsartan-hydrochlorothiazide 1719
VALTREX 1720
VANTAS 1721
VARUBI ORAL 1722
VASCEPA ORAL CAPSULE 0.5 GM 1723
VASCEPA ORAL CAPSULE 1 GM .. 1724
VECAMYL 1725
VELETRI 1726
VELTASSA 1727
VELTIN 1729
VEMLIDY 1730
VENCLEXTA ORAL TABLET 10 MG 1731
VENCLEXTA ORAL TABLET 100 MG 1732
VENCLEXTA ORAL TABLET 50 MG 1733
VENCLEXTA STARTING PACK 1734
venlafaxine hcl er oral capsule extended release 24 hour 150 mg 1739
venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg 1740
venlafaxine hcl er oral tablet extended release 24 hour 150 mg 1741
venlafaxine hcl er oral tablet extended release 24 hour 225 mg, 37.5 mg, 75 mg .1742
venlafaxine hcl oral tablet 100 mg, 25 mg 1735
venlafaxine hcl oral tablet 37.5 mg 1736
venlafaxine hcl oral tablet 50 mg 1737
venlafaxine hcl oral tablet 75 mg 1738
VENTAVIS 1743
verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg 1744

verapamil hcl er oral capsule extended release 24 hour 200 mg 1745
VERDROCET 1746
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 300 MG 1748
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG 1749
VERSACLOZ 1750
VERZENIO 1751
VESICARE 1752
VIBERZI 1753
vicodin es oral tablet 7.5-300 mg 1756
vicodin hp oral tablet 10-300 mg 1758
vicodin oral tablet 5-300 mg 1754
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 1760
VIEKIRA PAK 1761
VIEKIRA XR 1762
vigabatrin 1763
VIGADRONE 1764
VIIBRYD ORAL TABLET 1765
VIIBRYD STARTER PACK 1767
VIMIZIM 1769
VIMPAT ORAL SOLUTION 1770
VIMPAT ORAL TABLET 1771
VIOKACE 1772
VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG 1773
VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 400 MG 1774
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG 1775
VIREAD ORAL TABLET 300 MG 1776
VISTOGARD 1777
VISUDYNE 1778
VIVELLE-DOT 1779
VIZIMPRO 1780
VOLTAREN TRANSDERMAL 1781
VONVENDI 1782
VOSEVI 1783
VOTRIENT 1784
VPRIV 1785
VRAYLAR ORAL CAPSULE 1.5 MG 1786
VRAYLAR ORAL CAPSULE 3 MG 1788
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG 1790
VRAYLAR ORAL CAPSULE THERAPY PACK 1792
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG 1794
VYTORIN ORAL TABLET 10-80 MG 1795
VYVANSE ORAL CAPSULE 1796
VYVANSE ORAL TABLET CHEWABLE 1797
VYZULTA 1798
WELLBUTRIN SR 1799
WILATE INTRAVENOUS KIT 1800
XADAGO 1801
XALATAN 1802
XALKORI 1803
XARELTO ORAL TABLET 10 MG 1804
XARELTO ORAL TABLET 15 MG 1805
XARELTO ORAL TABLET 2.5 MG 1806
XARELTO ORAL TABLET 20 MG 1807
XARELTO STARTER PACK 1808
XATMEP 1809
XELJANZ ORAL TABLET 10 MG 1810
XELJANZ ORAL TABLET 5 MG 1811
XELJANZ XR 1812
XENAZINE ORAL TABLET 12.5 MG 1813
XENAZINE ORAL TABLET 25 MG 1814
XEOMIN 1815
XEPI 1816
XERMELO 1817
XGEVA 1818
XIFAXAN ORAL TABLET 200 MG 1819
XIFAXAN ORAL TABLET 550 MG 1820

XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG 1821
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG 1822
XODOL ORAL TABLET 5-300 MG, 7.5-300 MG 1823
XOLAIR 1825
XOPENEX HFA 1826
XTAMPZA ER 1827
XTANDI 1829
XULTOPHY 1830
XURIDEN 1831
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT 1832
XYNTHA SOLOFUSE 1833
XYREM 1834
XYZAL ALLERGY 24HR 1835
YONSA 1836
zafirlukast 1837
ZARXIO 1838
ZAVESCA 1839
ZEGERID OTC 1840
ZEJULA 1841
ZELBORAF 1842
ZEMAIRA 1843
ZEMBRACE SYMTOUCH 1844
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG 1845
zenatane oral capsule 10 mg, 20 mg, 40 mg 1846
ZENATANE ORAL CAPSULE 30 MG 1846
ZENZEDI ORAL TABLET 10 MG, 5 MG 1847
ZEPATIER 1848
ZETIA 1849
ZETONNA 1850
ZIANA 1851
zileuton er 1852
ZIOPTAN 1853
ziprasidone hcl 1854
ZOCOR 1855
ZOHYDRO ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 1856
ZOLADEX 1858
ZOLINZA 1859
zolmitriptan oral 1860
ZOLOFT ORAL TABLET 100 MG 1861
ZOLOFT ORAL TABLET 25 MG 1862
ZOLOFT ORAL TABLET 50 MG 1863
zolpidem tartrate er 1865
zolpidem tartrate oral 1864
ZOMACTON 1866
ZOMIG NASAL 1867
ZOMIG ORAL 1868
ZOMIG ZMT 1869
ZONALON 1870
ZONTIVITY 1871
ZORBTIVE 1872
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG 1873
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG 1874
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG 1875
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG 1876
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG 1877
ZURAMPIC 1878
ZYBAN 1879
ZYDELIG 1880
ZYFLO 1881
ZYFLO CR 1882
ZYKADIA 1883
ZYPREXA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG, 7.5 MG 1884
ZYPREXA ORAL TABLET 2.5 MG 1886
ZYPREXA ZYDIS 1888
ZYTIGA ORAL TABLET 250 MG 1889

ZYTIGA ORAL TABLET 500 MG....1890
ZYVOX ORAL SUSPENSION RECONSTITUTED.....1891
ZYVOX ORAL TABLET..... 1892