Abacavir Sulfate

Products Affected

- *abacavir sulfate oral solution*

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

Abacavir Sulfate

Products Affected

- *abacavir sulfate oral tablet*

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

Abacavir Sulfate-Lamivudine

Products Affected

- *abacavir sulfate-lamivudine*

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

Abacavir-Lamivudine-Zidovudine

Products Affected

- *abacavir-lamivudine-zidovudine*

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

Abilify

Products Affected
- abilify oral tablet 10 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourettes Disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourettes Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourettes Disorder AND There is clinical documentation indicating disease stability or improvement from baseline.

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine. FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER). FOR A DIAGNOSIS OF AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole OR risperidone). FOR A DIAGNOSIS OF TOURETTES DISORDER: Step is not required
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Abilify

Products Affected

- abilify oral tablet 15 mg, 2 mg, 20 mg, 30 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourettes Disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourettes Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourettes Disorder AND There is clinical documentation indicating disease stability or improvement from baseline.

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine. FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER). FOR A DIAGNOSIS OF AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole OR risperidone). FOR A DIAGNOSIS OF TOURETTES DISORDER: Step is not required
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Abiraterone Acetate

Products Affected

- *abiraterone acetate*

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

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 tablets Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Acamprosate Calcium

Products Affected

- *acamprosate calcium*

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

Accolate

Products Affected
- accolate

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

Accu-Chek Multiclix Lancet Dev

Products Affected
- accu-chek multiclix lancet dev

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

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acitretin

Products Affected
- *acitretin*

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

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/2019/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/2019/MUSC/Actemra.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Actemra.html
QL Criteria	4 SYRINGES Per 28 DAYSs
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Actemra ACTPen

Products Affected
- actemra actpen

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MUSC/Actemra.html
QL Criteria	4 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Acthar

Products Affected
- acthar

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 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/2019/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 24, 2018 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 lozenges Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: February 23, 2018 Quantity Limits: December 27, 2017

Activella

Products Affected
- activella oral tablet 1-0.5 mg

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

Actonel

Products Affected
- actonel oral tablet 150 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of generic alendronate
QL Criteria	1 tablet Per 28 Days
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 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 1 month of generic alendronate
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 Quantity Limits: August 25, 2015

Actonel

Products Affected
- actonel oral tablet 35 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of generic alendronate
QL Criteria	4 tablets Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 Quantity Limits: August 25, 2015

Actoplus Met

Products Affected
- actoplus met

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

Actos

Products Affected
- actos

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

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

Adapalene

Products Affected
- *adapalene external solution*

QL Criteria	2 ml 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 clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/pulmonaryhypertensionagents.html
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: September 24, 2018 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

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 clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/pulmonaryhypertensionagents.html
QL Criteria	3 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: September 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Duo

Products Affected
- advocate duo device

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

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/2019/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 24, 2018 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 12, 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

Aemcolo

Products Affected
- aemcolo

QL Criteria	12 tablets Per 1 fill
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 30 mg*

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

Afeditab CR

Products Affected

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

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

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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Afinitor Disperz

Products Affected
- afinitor disperz oral tablet soluble 2 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Afinitor Disperz

Products Affected
- afinitor disperz oral tablet soluble 3 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Afinitor Disperz

Products Affected
- afinitor disperz oral tablet soluble 5 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: September 09, 2019

Afrezza

Products Affected

- afrezza inhalation powder 12 unit, 8 unit, 90 x 8 unit & 90x12 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 unit, 90 x 4 unit & 90x8 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/2019/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 24, 2018 Step Therapy: August 25, 2015 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 fluticasone propionate/salmeterol inhaler and one of the following: Breo, Dulera, or Symbicort.
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: March 08, 2019 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 fluticasone propionate/salmeterol inhaler and one of the following: Breo, Dulera, or Symbicort.
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: March 08, 2019 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 fluticasone propionate/salmeterol inhaler and one of the following: Breo, Dulera, or Symbicort.
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

Ajovy

Products Affected
- ajovy

PA Criteria	Criteria Details
Covered Uses	The requested drug will be covered with prior authorization when the following criteria are met: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline OR The requested drug is being prescribed for the preventive treatment of migraine in an adult patient AND The patient experienced an inadequate treatment response with an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine) OR The patient experienced an intolerance or has a contraindication that would prohibit an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine)
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	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Continuation- 12 months if response of reduction in migraine days per month from baseline
ST Criteria	The requested drug will be covered with prior authorization when the following criteria are met: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline OR The requested drug is being prescribed for the preventive treatment of migraine in an adult patient AND The patient experienced an inadequate treatment response with an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine) OR The patient experienced an intolerance or has a contraindication that would prohibit an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine)
QL Criteria	1 injection Per 1 month
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 14, 2019 Quantity Limits: August 25, 2015

Aktipak

Products Affected
- aktipak

QL Criteria	2 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

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	1 packet Per 1 Day
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/2019/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 24, 2018 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alendronate Sodium

Products Affected

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

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

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 35 mg*

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

Alfuzosin HCl ER

Products Affected
- *alfuzosin hcl er*

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

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

Aliskiren Fumarate

Products Affected
- *aliskiren fumarate*

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

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

Allergy Relief

Products Affected

- *allergy relief oral tablet 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: June 14, 2019

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 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-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 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

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: August 25, 2015 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Altoprev

Products Affected
- altoprev

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

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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: February 13, 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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alunbrig

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: March 01, 2019 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

Alyq

Products Affected
- alyq

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

Ambien

Products Affected
- ambien oral tablet 10 mg

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: September 06, 2019

Ambien

Products Affected
- ambien oral tablet 5 mg

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

Ambien CR

Products Affected
- ambien cr

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

Ambrisentan

Products Affected
- *ambrisentan*

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 Step Therapy: August 25, 2015 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 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

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*

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	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 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

Annovera

Products Affected
- annovera

QL Criteria	1 ring Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: September 26, 2019

Anoro Ellipta

Products Affected
- anoro ellipta

QL Criteria	60 BLISTERS Per 30 DAYSs
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	5 tablets Per 1 month
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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 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 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apriso

Products Affected
- apriso

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

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, 600 mg

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

Aptiom

Products Affected
- aptiom oral tablet 400 mg, 800 mg

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

Aptivus

Products Affected
- aptivus oral capsule

QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Aptivus

Products Affected
- aptivus oral solution

QL Criteria	4 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arava

Products Affected
- arava

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 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

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: July 16, 2018

Arymo ER

Products Affected

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

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

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

Arzerra

Products Affected
- arzerra

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Arzerra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 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, Pentasa, or generic mesalamine.
QL Criteria	6 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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: March 19, 2019

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 CP24 Per 1 DAYS
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 capsule 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 oral tablet 16 mg, 4 mg, 8 mg

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

Atacand

Products Affected
- atacand oral tablet 32 mg

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

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 12, 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: February 12, 2018

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 1 month of generic alendronate
QL Criteria	4 tablets Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 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 tablet 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/2019/CNS/Aubagio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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/2019/MISC/Austedo.html
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Avalide

Products Affected
- avalide oral tablet 150-12.5 mg

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

Avalide

Products Affected
- avalide oral tablet 300-12.5 mg

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

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

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

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 and 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	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: March 13, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avodart

Products Affected
- avodart

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

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/2019/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: September 24, 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/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Azilect

Products Affected
- azilect

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

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 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Azulfidine

Products Affected
- azulfidine

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

Azulfidine EN-tabs

Products Affected
- azulfidine en-tabs

QL Criteria	8 TABS Per 1 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

Balversa

Products Affected
- balversa oral tablet 3 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/balversa.html
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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Balversa

Products Affected
- balversa oral tablet 4 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/balversa.html
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 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Balversa

Products Affected
- balversa 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/2019/ANEOP/balversa.html
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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Banzel

Products Affected
- banzel oral tablet

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

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

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

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 films 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/2019/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 24, 2018 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 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 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 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 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/2019/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/2019/MISC/benlysta.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/benlysta.html
QL Criteria	4 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Benzhydrocodone-Acetaminophen

Products Affected
- *benzhydrocodone-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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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 daily Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 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 12, 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: August 25, 2015

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/2019/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/2019/MISC/hereditary_angioedema.html
QL Criteria	1 vial Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: June 17, 2019

Betamethasone Dipropionate

Products Affected

- *betamethasone dipropionate external cream*

QL Criteria	120 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

Betamethasone Dipropionate

Products Affected

- *betamethasone dipropionate external ointment*

QL Criteria	120 grams Per 1 month
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 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 ointment*

QL Criteria	120 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

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/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: February 14, 2018

Bethkis

Products Affected
- bethkis

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

Bevespi Aerosphere

Products Affected
- bevespi aerosphere

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
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 23, 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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bicalutamide

Products Affected
- *bicalutamide*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 12, 2019

Bijuva

Products Affected
- bijuva

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

Biktarvy

Products Affected
- biktarvy

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

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 intravenous solution 5 gm/50ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Boniva

Products Affected
- boniva oral tablet 150 mg

QL Criteria	0.04 tabs Per 1 DAYS
Notes/ References	
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: April 16, 2018

Bosentan

Products Affected
- *bosentan*

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bosulif

Products Affected
- bosulif

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: January 09, 2018

Botox

Products Affected
- botox

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/botulinum_toxin.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Breo Ellipta

Products Affected

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

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

Breo Ellipta

Products Affected

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

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

Brisdelle

Products Affected
- brisdelle

PA Criteria	Criteria Details
Covered Uses	Moderate to severe vasomotor symptoms associated with menopause
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
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 22, 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 Striverdi (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	4 ml Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 06, 2019 Quantity Limits: June 28, 2019

Bryhali

Products Affected
- bryhali

ST Criteria	A documented step through augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	60 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 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, 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	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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine

Products Affected

- *buprenorphine transdermal*

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 film*

QL Criteria	3 films Per 1 Day
Notes/ References	
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 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

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

QL Criteria	180 day supply Per 365 Days
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 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 (XL)

Products Affected

- *bupropion hcl er (xl) oral tablet extended release 24 hour 150 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 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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 30 Days
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 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 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 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 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Cablivi

Products Affected
- cablivi

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/cablivi.html
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 day, 2 courses (58 day supply) Per 1 lifetime
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cabometyx

Products Affected
- cabometyx oral tablet 20 mg, 40 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cabometyx

Products Affected
- cabometyx oral tablet 60 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Calcipotriene

Products Affected

- *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 month
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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: December 12, 2017

Canasa

Products Affected
- canasa

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

Candesartan Cilexetil

Products Affected

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

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

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz*

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

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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cardizem LA

Products Affected

- cardizem la oral tablet extended release 24 hour 120 mg

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

Cardizem LA

Products Affected

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

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

Cardizem LA

Products Affected

- cardizem la oral tablet extended release 24 hour 240 mg

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

Cardizem LA

Products Affected

- cardizem la oral tablet extended release 24 hour 360 mg

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

Cardura XL

Products Affected
- cardura xl

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

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/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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 TABS Per 1 DAYS
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	84 mls Per 56 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 11, 2018

CeleBREX

Products Affected
- celebrex

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

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 tabs Per 1 DAYS
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

Cequa

Products Affected
- cequa

ST Criteria	A documented trial of one month of Restasis
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: January 07, 2019 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/2019/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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 24, 2018 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	180 day supply Per 365 Days
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	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Chantix Starting Month Pak

Products Affected
- chantix starting month pak

QL Criteria	180 day supply Per 365 Days
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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciclodan

Products Affected
- ciclodan external solution

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

Ciclopirox

Products Affected
- *ciclopirox external solution*

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

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: May 14, 2018

Cimzia

Products Affected
- cimzia subcutaneous kit 2 x 200 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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 24, 2018 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/2019/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/2019/MISC/hereditary_angioedema.html
QL Criteria	17 vials Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Citalopram Hydrobromide

Products Affected

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

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

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 40 mg*

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

Claravis

Products Affected
- *claravis oral capsule 10 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 TABS Per 1 DAYS
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 TB12 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code

Products Affected
- clever chek auto-code

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

Climara

Products Affected
- climara

QL Criteria	0.15 patch Per 1 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	1 box (4 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clindamycin Phosphate

Products Affected

- *clindamycin phosphate external solution*

QL Criteria	2 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

CloBAZam

Products Affected

- *clobazam oral tablet*

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

Clobetasol Propionate

Products Affected

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

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

Clobetasol Propionate

Products Affected

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

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

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*
- *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 E

Products Affected

- *clobetasol propionate e*

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

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

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*

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

Clotrimazole-Betamethasone

Products Affected

- *clotrimazole-betamethasone external cream*

QL Criteria	45 grams Per 1 month
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 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

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	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine).
QL Criteria	9 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine).
QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 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/2019/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 24, 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Coditussin AC

Products Affected
- *coditussin ac*

PA Criteria	Criteria Details
Covered Uses	The member is aged 6 years or older AND The member does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30) AND The member has tried and failed at least one non-opioid containing cough and cold remedy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
QL Criteria	60 ml per day over 5 days Per 30 day periods
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

Colazal

Products Affected
- colazal

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine, Delzicol, or Pentasa.
QL Criteria	9 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 Quantity Limits: January 30, 2018

Colchicine

Products Affected
- *colchicine oral*

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

CombiPatch

Products Affected
- combipatch

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

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

Combivir

Products Affected
- combivir

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

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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 kits Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 caupsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 kits Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Complera

Products Affected
- complera

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

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 20 mg/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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	
QL Criteria	1 syringe Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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	
QL Criteria	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

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/2019/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 %
- cordran external lotion

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

Cordran

Products Affected
- cordran external tape

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

Coreg CR

Products Affected
- coreg cr

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Corlanor

Products Affected
- corlanor oral tablet

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 (ARB), or ARB/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: October 05, 2019 Quantity Limits: August 25, 2015

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/2019/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/2019/MUSC/Cosentyx.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Cosentyx.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/ANEOP/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: January 14, 2019 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

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Cozaar

Products Affected
- cozaar oral tablet 25 mg, 50 mg

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

Crixivan

Products Affected
- crixivan oral capsule 200 mg

QL Criteria	15 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

Crixivan

Products Affected
- crixivan oral capsule 400 mg

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

Cuvitru

Products Affected

- cuvitru subcutaneous solution 1 gm/5ml, 2 gm/10ml, 4 gm/20ml, 8 gm/40ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

CVS Nicotine

Products Affected

- *cvs nicotine transdermal patch 24 hour 14 mg/24hr, 7 mg/24hr*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CVS Nicotine Polacrilex

Products Affected

- *cvs nicotine polacrilex mouth/throat lozenge 4 mg*

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

CVS Omeprazole-Sod Bicarbonate

Products Affected

- *cvs omeprazole-sod bicarbonate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Cycloset

Products Affected
- cycloset

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

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

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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 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, generic fluticasone propionate/salmeterol or Spiriva
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

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, generic fluticasone propionate/salmeterol or Spiriva
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

Dapsone

Products Affected
- *dapsone external*

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

Darifenacin Hydrobromide ER

Products Affected

- *darifenacin hydrobromide er*

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

Daurismo

Products Affected
- daurismo 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/daurismo.html
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: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daurismo

Products Affected
- daurismo 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/ANEOPL/daurismo.html
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: December 12, 2018 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

Deferasirox

Products Affected
- *deferasirox*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 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/2019/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ID/antiviral_hiv.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Demser

Products Affected
- demser

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CV/antihypertensive_misc.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 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/2019/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 24, 2018 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

Desoximetasone

Products Affected

- *desoximetasone external ointment 0.25 %*

QL Criteria	120 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 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 tablets Per 1 DAYS
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 TB24 Per 1 DAYS
Notes/ References	Annual Review: 05/2017

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 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

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 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 23, 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 capsule Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 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 DAYS
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 milliliters Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

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

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

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

Diacomit

Products Affected
- diacomit oral capsule

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/diacomit.html
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 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diacomit

Products Affected
- diacomit oral packet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/diacomit.html
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: 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: August 25, 2015

DiazePAM

Products Affected
- *diazepam rectal*

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

Dibenzyline

Products Affected
- dibenzyline

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CV/antihypertensive_misc.html
QL Criteria	12 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Diclofenac Epolamine

Products Affected
- *diclofenac epolamine*

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

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 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

Didanosine

Products Affected

- *didanosine oral capsule delayed release 200 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Didanosine

Products Affected

- *didanosine oral capsule delayed release 250 mg, 400 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

Differin

Products Affected

- differin external gel 0.1 %, 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 tablets Per 1 fill
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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	9 ML Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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, 300 mg, 360 mg*

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Beads

Products Affected

- *diltiazem hcl er beads oral capsule extended release 24 hour 420 mg*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: May 03, 2019

DilTIAZem HCl ER Beads

Products Affected

- *diltiazem hcl er beads oral capsule extended release 24 hour 180 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 120 mg*

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

DilTIAZem HCl ER Coated Beads

Products Affected

- *diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg, 300 mg, 360 mg*

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

DilTIAZem HCl ER Coated Beads

Products Affected

- *diltiazem hcl er coated beads oral capsule extended release 24 hour 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

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

Diovan HCT

Products Affected

- diovan hct oral tablet 160-12.5 mg, 160-25 mg, 80-12.5 mg

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

Diovan HCT

Products Affected

- diovan hct oral tablet 320-12.5 mg, 320-25 mg

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

Dipentum

Products Affected
- dipentum

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine, Delzicol, or Pentasa.
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 Quantity Limits: August 25, 2015

Ditropan XL

Products Affected

- ditropan xl oral tablet extended release 24 hour 10 mg, 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	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Divigel

Products Affected
- divigel transdermal gel 0.75 mg/0.75gm

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

Dolophine

Products Affected
- dolophine oral tablet 10 mg

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

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/2019/MISC/thrombopoietin_receptor_agonists.html
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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: July 16, 2018

Dovato

Products Affected
- dovato

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

Dovonex

Products Affected
- dovonex external cream

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a medium to high potency topical steroid
QL Criteria	120 grams 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

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

Doxylamine-Pyridoxine

Products Affected
- *doxylamine-pyridoxine*

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 08, 2019

D-Penamine

Products Affected
- *d-penamine*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 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 capsules Per 1 day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Duavee

Products Affected
- duavee

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

Duetact

Products Affected
- duetact

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

Dulera

Products Affected
- dulera

QL Criteria	2 inhalers Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 20 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

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 30 mg, 40 mg*

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

Duobrii

Products Affected
- duobrii

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

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/2019/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/2019/CNS/antiparkinsons.html
QL Criteria	100 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Dupixent

Products Affected
- dupixent

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: October 09, 2019

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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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

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/2019/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 24, 2018 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 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 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 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Edurant

Products Affected
- edurant

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

Efavirenz

Products Affected
- *efavirenz oral capsule*

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

Efavirenz

Products Affected
- *efavirenz 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

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 caps Per 1 DAYS
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 tablet Per 1 day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: May 22, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 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/2019/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 24, 2018 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

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/2019/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 24, 2018 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: August 25, 2015

Eliquis

Products Affected
- eliquis oral tablet 5 mg

QL Criteria	75 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 13, 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

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/2019/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 24, 2018 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	The requested drug will be covered with prior authorization when the following criteria are met: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline OR The requested drug is being prescribed for the preventive treatment of migraine in an adult patient AND The patient experienced an inadequate treatment response with an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine) OR The patient experienced an intolerance or has a contraindication that would prohibit an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine)
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	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Continuation- 12 months if response of reduction in migraine days per month from baseline
ST Criteria	The requested drug will be covered with prior authorization when the following criteria are met: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline OR The requested drug is being prescribed for the preventive treatment of migraine in an adult patient AND The patient experienced an inadequate treatment response with an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine) OR The patient experienced an intolerance or has a contraindication that would prohibit an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine)
QL Criteria	1 injection Per 1 month
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 14, 2019 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 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emtriva

Products Affected
- emtriva oral solution

QL Criteria	4 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Emverm

Products Affected
- emverm

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

Enablex

Products Affected

- enablex oral tablet extended release 24 hour 15 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 tablet Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Enablex

Products Affected

- enablex oral tablet extended release 24 hour 7.5 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 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 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/2019/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/2019/MUSC/Enbrel.html
QL Criteria	4 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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/2019/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/2019/MUSC/Enbrel.html
QL Criteria	8 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Enbrel

Products Affected
- enbrel subcutaneous solution reconstituted

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MUSC/Enbrel.html
QL Criteria	8 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Enbrel.html
QL Criteria	8 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Enbrel.html
QL Criteria	8 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Endocet

Products Affected

- endocet oral tablet 2.5-325 mg
- *endocet oral tablet 5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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/2019/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/2019/MUSC/Entyvio.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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: September 24, 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/2019/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/2019/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

Epivir

Products Affected
- epivir oral solution

QL Criteria	4 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Epivir

Products Affected
- epivir oral tablet 150 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Epivir

Products Affected
- epivir 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: June 28, 2019

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/2019/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Erythropoiesis_Stimulating_Agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Epoprostenol Sodium

Products Affected

- *epoprostenol sodium*

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

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

Epzicom

Products Affected
- epzicom

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

EQ Nicotine

Products Affected

- *eq nicotine transdermal*

QL Criteria	180 day supply Per 365 Days
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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: March 15, 2018

Erlotinib HCl

Products Affected
- *erlotinib hcl 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: July 08, 2019

Erlotinib HCl

Products Affected
- *erlotinib hcl 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Erlotinib HCl

Products Affected
- *erlotinib hcl 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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 tablet 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 oral capsule delayed release*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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*

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

Estrogel

Products Affected
- estrogel

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

Eszopiclone

Products Affected
- *eszopiclone*

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Evamist

Products Affected
- evamist

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

Evotaz

Products Affected
- evotaz

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

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

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

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

Exforge HCT

Products Affected
- exforge hct

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

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/2019/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 24, 2018 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/2019/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/2019/CNS/MSInterferons.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Famciclovir

Products Affected

- *famciclovir oral tablet 125 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

Famciclovir

Products Affected

- *famciclovir oral tablet 250 mg*

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

Famciclovir

Products Affected

- *famciclovir oral tablet 500 mg*

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

Fanapt

Products Affected
- fanapt

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine)
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Fanapt Titration Pack

Products Affected
- fanapt titration pack

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 21, 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: August 25, 2015

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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 EA Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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 two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	9 tabs Per 1 DAYS
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 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 two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	1 tabs Per 1 DAYS
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 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 two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	6 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 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 two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 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 two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	3 tabs Per 1 DAYS
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Febuxostat

Products Affected
- *febuxostat*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of generic allopurinol
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 06, 2019 Quantity Limits: September 09, 2019

Felodipine ER

Products Affected
- *felodipine er*

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

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 tablet 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 capsule 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: August 25, 2015

Fenofibric Acid

Products Affected

- *fenofibric acid oral tablet 105 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: September 09, 2019

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 tablet 200 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))
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 14, 2019

fentaNYL Citrate

Products Affected

- *fentanyl citrate buccal tablet 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))
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FentaNYL Citrate

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

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 Lozenges Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: February 23, 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 23, 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/2019/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 24, 2018 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 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 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 CP24 Per 1 DAYS
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 2018 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/2019/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 24, 2018 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Firdapse

Products Affected
- firdapse

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bullentin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/firdapse.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	Refer to the clinical policy bulletin above for details
QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flolan

Products Affected
- flolan

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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: August 25, 2015

Fluocinonide

Products Affected

- *fluocinonide external cream*

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 cream*

ST Criteria	A documented step through augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 26, 2018 Quantity Limits: August 25, 2015

Fluocinonide

Products Affected

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

Fluocinonide Emulsified Base

Products Affected

- *fluocinonide emulsified base*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 40 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 60 mg*

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

Flurandrenolide

Products Affected
- *flurandrenolide external cream*

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: August 25, 2015

Fluticasone-Salmeterol

Products Affected

- *fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose*

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

Fluticasone-Salmeterol

Products Affected

- *fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 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

Fluticasone-Salmeterol

Products Affected

- *fluticasone-salmeterol inhalation aerosol powder breath activated 55-14 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: March 19, 2019

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

Fluvastatin Sodium ER

Products Affected

- *fluvastatin sodium er*

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

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 25 mg, 50 mg*

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

FluvoxaMINE Maleate ER

Products Affected

- *fluvoxamine maleate er*

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

Focalin

Products Affected
- focalin

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

FORA D10 2-in-1 Monitor

Products Affected
- fora d10 2-in-1 monitor

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

FORA D15g 2-in-1 Monitor

Products Affected
- fora d15g 2-in-1 monitor

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

FORA D20 2-in-1 Monitor

Products Affected
- fora d20 2-in-1 monitor

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

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/2019/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/2019/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Fosamax

Products Affected
- fosamax oral tablet 70 mg

QL Criteria	0.15 tabs Per 1 DAYS
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

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

Fosamprenavir Calcium

Products Affected

- *fosamprenavir calcium*

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

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

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fulvestrant

Products Affected
- *fulvestrant*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fuzeon

Products Affected

- fuzeon subcutaneous solution reconstituted

QL Criteria	2 vials Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

Fycompa

Products Affected
- fycompa oral tablet

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

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gabapentin

Products Affected

- *gabapentin oral tablet*

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

Gabitril

Products Affected
- gabitril oral tablet 12 mg, 4 mg

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

Gabitril

Products Affected
- gabitril oral tablet 16 mg

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

Gabitril

Products Affected
- gabitril oral tablet 2 mg

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

Galafold

Products Affected
- galafold

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/galafold.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	14 capsules Per 28 days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Gammaked

Products Affected

- gammaked injection solution 10 gm/100ml, 20 gm/200ml, 5 gm/50ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Gammaplex

Products Affected

- gammaplex intravenous solution 10 gm/100ml, 10 gm/200ml, 20 gm/200ml, 20 gm/400ml, 5 gm/100ml, 5 gm/50ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/MISC/Gattex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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 23, 2018 Quantity Limits: August 25, 2015

Gelnique Pump

Products Affected
- gelnique pump

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 23, 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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Genotropin

Products Affected
- genotropin

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Genotropin MiniQuick

Products Affected
- genotropin miniquick

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

GenVisc 850

Products Affected
- genvisc 850

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ID/antiviral_hiv.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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 two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	2 CAPS Per 1 DAYS
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Gilenya

Products Affected
- gilenya

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: July 16, 2018

Gilotrif

Products Affected
- gilotrif

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glatiramer Acetate

Products Affected

- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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	
QL Criteria	1 syringe Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glatiramer Acetate

Products Affected

- *glatiramer acetate 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/2019/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	
QL Criteria	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glatopa

Products Affected

- glatopa subcutaneous solution prefilled syringe 20 mg/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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	
QL Criteria	1 syringe Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glatopa

Products Affected

- glatopa 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/2019/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	
QL Criteria	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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 Diagnostic

Products Affected
- glucagen diagnostic

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

GlucaGen HypoKit

Products Affected
- glucagen hypokit

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

Glucagon Emergency

Products Affected
- glucagon emergency

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

Glyxambi

Products Affected
- glyxambi

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

Gralise

Products Affected
- gralise oral tablet 300 mg

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

Gralise

Products Affected
- gralise oral tablet 600 mg

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

Gralise Starter

Products Affected
- gralise starter

ST Criteria	A documented contraindication, intolerance, allergy, or failure of gabapentin
QL Criteria	1 starter pack 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

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/2019/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/2019/MISC/G-CSF.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Grastek

Products Affected
- grastek

PA Criteria	Criteria Details
Covered Uses	Grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 5 through 65 years of age
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of any severe systemic allergic reaction, history of severe local reaction to sublingual allergen immunotherapy
Required Medical Information	A documented diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 5 through 65 years of age, confirmation with either a positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross reactive grass pollen.
Age Restrictions	5 through 65 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 13, 2018

GuanFACINE HCl ER

Products Affected
- *guanfacine hcl er*

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

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/2019/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/2019/MISC/hereditary_angioedema.html
QL Criteria	16 kits Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Halobetasol Propionate

Products Affected

- *halobetasol propionate external cream*
- *halobetasol propionate external ointment*

QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Harvoni

Products Affected
- harvoni oral tablet 90-400 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Heartburn Treatment 24 Hour

Products Affected

- *heartburn treatment 24 hour oral capsule delayed release 15 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hepsera

Products Affected
- hepsera

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

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/2019/CNS/sedative-hypnotics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HM Nicotine

Products Affected

- *hm nicotine*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HM Nicotine Polacrilex

Products Affected

- *hm nicotine polacrilex mouth/throat lozenge 2 mg*

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

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: August 25, 2015 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	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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humatrope

Products Affected
- humatrope

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Humira.html
QL Criteria	2 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: May 14, 2018

Humira

Products Affected

- humira subcutaneous prefilled syringe kit
  10 mg/0.2ml, 20 mg/0.4ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MUSC/Humira.html
QL Criteria	2 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Humira.html
QL Criteria	6 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: May 15, 2018

Humira

Products Affected

- humira subcutaneous prefilled syringe kit
  40 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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/2019/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/2019/MUSC/Humira.html
QL Criteria	3 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: May 15, 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/2019/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/2019/MUSC/Humira.html
QL Criteria	2 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: May 14, 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/2019/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/2019/MUSC/Humira.html
QL Criteria	6 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: May 15, 2018

Humira Pen

Products Affected

- humira pen subcutaneous pen-injector kit
  40 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Humira.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 08, 2018

Humira Pen-Ps/UV/Adol HS Start

Products Affected

- humira pen-ps/uv/adol hs start 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/2019/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/2019/MUSC/Humira.html
QL Criteria	6 inections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Humira Pen-Ps/UV/Adol HS Start

Products Affected

- humira pen-ps/uv/adol hs start 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/2019/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/2019/MUSC/Humira.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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/2019/ANEOP/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: January 14, 2019 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: February 13, 2018

Hydrocodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hydrocodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HYDROcodone-Acetaminophen

Products Affected

- *hydrocodone-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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HYDROcodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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/2019/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 24, 2018 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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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

Ibandronate Sodium

Products Affected

- *ibandronate sodium intravenous solution 3 mg/3ml*

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Ibandronate Sodium

Products Affected
- *ibandronate sodium oral*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of generic alendronate
QL Criteria	1 tablet Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	21 EA Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Icatibant Acetate

Products Affected
- *icatibant acetate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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	6 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: September 09, 2019

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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 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/2019/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 24, 2018 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/2019/ANEOP/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: March 01, 2019 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/2019/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 24, 2018 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/2019/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/2019/MUSC/Ilumya.html
QL Criteria	1 syringe Per 84 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imbruvica

Products Affected
- imbruvica oral capsule 140 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: April 17, 2018

Imbruvica

Products Affected
- imbruvica oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imiquimod

Products Affected
- *imiquimod external*

QL Criteria	1 packet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

Imitrex

Products Affected
- imitrex nasal

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

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: August 25, 2015

Imitrex

Products Affected
- imitrex subcutaneous

QL Criteria	10 vials/30 days Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

Imitrex STATdose Refill

Products Affected

- imitrex statdose refill subcutaneous solution cartridge

QL Criteria	10 cart/30 days Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

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: August 25, 2015

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	84 capsules Per 28 days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 16, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Inbrija

Products Affected
- inbrija

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/inbrija.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	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/inbrija.html
QL Criteria	10 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: April 08, 2019 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/2019/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 24, 2018 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: April 08, 2019

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/2019/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/2019/MUSC/Inflectra.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: November 10, 2017

Ingrezza

Products Affected
- ingrezza oral capsule therapy pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Inlyta

Products Affected
- inlyta oral tablet 1 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

Inlyta

Products Affected
- inlyta 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/2019/ANEOP/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: January 14, 2019 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 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

InnoPran XL

Products Affected

- innopran xl oral capsule extended release 24 hour 80 mg

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

Intelence

Products Affected
- intelence oral tablet 100 mg, 25 mg

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

Intelence

Products Affected
- intelence oral tablet 200 mg

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

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/2019/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: September 24, 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 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

Invega

Products Affected

- invega oral tablet extended release 24 hour
  1.5 mg, 3 mg, 9 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Schizoaffective disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia or Schizoaffective disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Schizophrenia or Schizoaffective disorder AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine).
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Invega

Products Affected

- invega oral tablet extended release 24 hour 6 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Schizoaffective disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia or Schizoaffective disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Schizophrenia or Schizoaffective disorder AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine).
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Invirase

Products Affected
- invirase 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: June 13, 2019

Invokamet

Products Affected
- invokamet

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

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	2 tablets 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 month
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 tablet 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 tablet 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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: June 28, 2019

Isentress

Products Affected
- isentress 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: June 12, 2019

Isentress

Products Affected
- isentress oral tablet

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

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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet

Products Affected
- janumet

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

Janumet XR

Products Affected

- janumet xr oral tablet extended release 24 hour 100-1000 mg, 50-500 mg

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

Janumet XR

Products Affected

- janumet xr oral tablet extended release 24 hour 50-1000 mg

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

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 tablet Per 1 Day
Notes/ References	
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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jevtana

Products Affected
- jevtana

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/jevtana.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juluca

Products Affected
- juluca

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ID/antiviral_hiv.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 Quantity Limits: January 09, 2018

Juxtapid

Products Affected
- juxtapid oral capsule 10 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/Antilipidemic_Agents_HOFH.html
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

- juxtapid oral capsule 20 mg, 30 mg, 40 mg, 5 mg, 60 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/Antilipidemic_Agents_HOFH.html
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Jynarque

Products Affected
- jynarque 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/2019/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: September 24, 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	
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 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/2019/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/2019/MISC/hereditary_angioedema.html
QL Criteria	12 vials Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: June 17, 2019

Kaletra

Products Affected
- kaletra oral solution

QL Criteria	3 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kaletra

Products Affected
- kaletra oral tablet 100-25 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

Kaletra

Products Affected
- kaletra oral tablet 200-50 mg

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Kalydeco

Products Affected
- kalydeco oral packet 25 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kalydeco

Products Affected
- kalydeco oral packet 50 mg, 75 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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

Kepivance

Products Affected
- kepivance

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 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 TB24 Per 1 DAYS
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 TB24 Per 1 DAYS
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

Ketoconazole

Products Affected
- *ketoconazole external cream*

QL Criteria	2 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

Ketoconazole

Products Affected

- *ketoconazole oral*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: July 03, 2019

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

QL Criteria	20 tablets Per 5 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Keveyis

Products Affected
- keveyis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 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/2019/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/2019/MUSC/Kevzara.html
QL Criteria	2 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: July 02, 2018

Khedezla

Products Affected
- khedezla

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
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 TB24 Per 1 DAYS
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 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/2019/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/2019/MUSC/Kineret.html
QL Criteria	1 syringe Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Kisqali Femara (400 MG Dose)

Products Affected
- kisqali femara (400 mg dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kisqali Femara (600 MG Dose)

Products Affected
- kisqali femara (600 mg dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kisqali Femara(200 MG Dose)

Products Affected
- kisqali femara(200 mg dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kitabis Pak

Products Affected
- kitabis pak

QL Criteria	10 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/ENDO/korlym.html
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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kovaltry

Products Affected

- kovaltry intravenous solution reconstituted 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/2019/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 24, 2018 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/2019/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/2019/ENDO/gout.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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 24, 2018 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

LamiVUDine

Products Affected
- *lamivudine oral solution*

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

LamiVUDine

Products Affected

- *lamivudine oral tablet 150 mg*

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

LamiVUDine

Products Affected

- *lamivudine 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: June 28, 2019

Lamivudine-Zidovudine

Products Affected
- *lamivudine-zidovudine*

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

LamoTRIgine

Products Affected

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

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

QL Criteria	6 TAB Per 1 DAILY
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

QL Criteria	3 TAB Per 1 DAILY
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 19, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Latuda

Products Affected
- latuda oral tablet 120 mg, 20 mg, 40 mg

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER).
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Latuda

Products Affected
- latuda oral tablet 60 mg

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER).
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Latuda

Products Affected
- latuda oral tablet 80 mg

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER).
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Leflunomide

Products Affected
- *leflunomide oral*

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

Lemtrada

Products Affected
- lemtrada

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/Lemtrada.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 ml (5 vials) Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/ANEOP/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 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lescol XL

Products Affected
- lescol xl

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

Letairis

Products Affected
- letairis

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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/2019/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 24, 2018 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 tablets 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 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride 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: June 14, 2019

Levorphanol Tartrate

Products Affected
- *levorphanol tartrate 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levorphanol Tartrate

Products Affected

- *levorphanol tartrate oral tablet 3 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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

Lexiva

Products Affected
- lexiva oral suspension

QL Criteria	8 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

Lexiva

Products Affected
- lexiva 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: June 12, 2019

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 pregablin.
QL Criteria	3 patches Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: September 08, 2019 Quantity Limits: August 25, 2015

Lidocaine HCl

Products Affected
- *lidocaine hcl external solution*

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 ml Per 30 Days
Notes/ References	
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

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

Lipofen

Products Affected
- lipofen

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

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 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

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).
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of sodium polystyrene sulfonate
Notes/ References	

Revision Date	Prior Authorization: September 19, 2018 Step Therapy: March 05, 2019 Quantity Limits: August 25, 2015

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: April 16, 2018

Lonhala Magnair Starter Kit

Products Affected
- lonhala magnair starter kit

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lopinavir-Ritonavir

Products Affected
- *lopinavir-ritonavir*

QL Criteria	3 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Lopreeza

Products Affected
- lopreeza

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

Lorbrena

Products Affected
- lorbrena oral tablet 100 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

Lorbrena

Products Affected
- lorbrena oral tablet 25 mg

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

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

PA Criteria	Criteria Details
Other Criteria	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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

Lotrisone

Products Affected
- lotrisone external cream

QL Criteria	45 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

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: August 25, 2015 Quantity Limits: August 25, 2015

Lovastatin

Products Affected
- *lovastatin*

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

Lovaza

Products Affected
- lovaza

QL Criteria	4 CAPS Per 1 DAYS
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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lunesta

Products Affected
- lunesta

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

Lupaneta Pack

Products Affected
- lupaneta pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lyrica CR

Products Affected

- lyrica cr oral tablet extended release 24 hour 165 mg

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: February 12, 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: February 12, 2018

Lyrica CR

Products Affected

- lyrica cr oral tablet extended release 24 hour 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: August 25, 2015

Lysteda

Products Affected
- lysteda

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

Macugen

Products Affected
- macugen

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 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/2019/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/hydroxyprogesterone.html
QL Criteria	21 syringes Per 365 days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: March 05, 2019 Quantity Limits: April 16, 2018

Maprotiline HCl

Products Affected
- *maprotiline hcl*

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

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

Matzim LA

Products Affected

- *matzim la oral tablet extended release 24 hour 240 mg*

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

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/2019/GI/Mavyret.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 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 12, 2018

Maxalt-MLT

Products Affected
- maxalt-mlt oral tablet dispersible 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: 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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 07, 2018

Memantine HCl ER

Products Affected
- *memantine hcl er*

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

Menostar

Products Affected
- menostar

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

Meperidine HCl

Products Affected
- *meperidine hcl oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 capsule delayed release*

QL Criteria	12 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: July 08, 2019

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 1.2 gm*

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

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 800 mg*

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

Mesalamine

Products Affected

- *mesalamine rectal suppository*

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

Metadate ER

Products Affected

- metadate er oral tablet extended release 20 mg

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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

Methamphetamine HCl

Products Affected
- *methamphetamine hcl*

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

Methergine

Products Affected
- methergine oral

QL Criteria	4 tablets Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylin

Products Affected
- methylin oral solution 10 mg/5ml

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 soln Per 1 DAYS
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 milliliters Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl

Products Affected

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

QL Criteria	60 milliliters Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

QL Criteria	6 tablet Per 1 Day
Notes/ References	Annual Review: 10/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 12, 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 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

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: April 16, 2018

Methylphenidate HCl ER (LA)

Products Affected

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

QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: 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 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 200 mg*

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

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 25 mg*

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

Miacalcin

Products Affected
- miacalcin injection

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Miacalcin

Products Affected
- miacalcin nasal

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/bone_disease_agents.html
QL Criteria	1 bottle Per 30 Days
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Micardis

Products Affected
- micardis oral tablet 20 mg, 40 mg

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

Micardis

Products Affected
- micardis oral tablet 80 mg

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

Micardis HCT

Products Affected
- micardis hct oral tablet 40-12.5 mg

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

Micardis HCT

Products Affected

- micardis hct oral tablet 80-12.5 mg, 80-25 mg

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: May 14, 2018

Mimvey

Products Affected
- *mimvey*

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

Mirapex ER

Products Affected
- mirapex er

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

Mircera

Products Affected
- mircera injection solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mirtazapine

Products Affected
- *mirtazapine oral*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 05, 2019

Mitigare

Products Affected
- mitigare

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

Modafinil

Products Affected
- *modafinil oral tablet 100 mg*

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

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

Modafinil

Products Affected
- *modafinil oral tablet 200 mg*

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

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

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/2019/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 24, 2018 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/2019/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 24, 2018 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 tablet 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: August 25, 2015

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate (Concentrate)

Products Affected

- *morphine sulfate (concentrate) oral solution 20 mg/ml*

QL Criteria	4.5 mls Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 12, 2019

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

Motegrity

Products Affected
- motegrity

PA Criteria	Criteria Details
Covered Uses	Chronic idiopathic constipation in adult patient?s 18 years or older
Exclusion Criteria	Intestinal perforation or obstruction due to structural or functional disorder of the gut wall, obstructive ileus, severe inflammatory conditions of the intestinal tract such as Crohn's disease, ulcerative colitis, and toxic megacolon/mega-rectum.
Required Medical Information	A documented diagnosis of chronic constipation defined as having fewer than 3 spontaneous bowel movements (SBMs) per week that resulted in a feeling of complete evacuation (complete, spontaneous bowel movement [CSBM]) and 1 or more of the following symptoms (Lumpy or hard stools, Sensation of incomplete evacuation, Straining at defecation) for greater than 25% of bowel movements in the preceding 3 months, with symptoms onset more than 6 months prior to screening AND failure of laxative therapy.
Age Restrictions	18 years 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 preferred product (2 week trial and failure of Trulance or Linzess).
QL Criteria	1 tablet Per 1 day
Notes/ References	

Revision Date	Prior Authorization: April 01, 2019 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Movantik

Products Affected
- movantik

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mozobil

Products Affected
- mozobil

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Mozobil.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/MISC/thrombopoietin_receptor_agonists.html
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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Multaq

Products Affected
- multaq

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

Mupirocin

Products Affected
- *mupirocin external*

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

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/2019/ENDO/Myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.5 VIAL Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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

Myobloc

Products Affected

- myobloc intramuscular solution 2500 unit/0.5ml, 5000 unit/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, solifenacin)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 11, 2019 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 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

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/2019/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 24, 2018 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

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	4 sprays Per 30 days and a 30 day supply per fills
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nasacort Allergy 24HR

Products Affected
- nasacort allergy 24hr

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: June 28, 2019

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/2019/ANEOP/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: March 01, 2019 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/2019/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/2019/MISC/G-CSF.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Neulasta Onpro

Products Affected
- neulasta onpro

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/G-CSF.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Neupogen

Products Affected

- neupogen injection solution 300 mcg/ml, 480 mcg/1.6ml
- neupogen injection solution prefilled syringe

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/G-CSF.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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 cap Per 1 DAYS
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 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neutek 2Tek Glucose/Pressure

Products Affected
- neutek 2tek glucose/pressure

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

Nevirapine

Products Affected

- *nevirapine oral suspension*

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

Nevirapine

Products Affected
- *nevirapine oral tablet*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Nevirapine ER

Products Affected

- *nevirapine er oral tablet extended release 24 hour 100 mg*

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

Nevirapine ER

Products Affected

- *nevirapine er oral tablet extended release 24 hour 400 mg*

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

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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexIUM

Products Affected
- nexium oral packet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 packet per day, 90 day supply Per 365 Days
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

NexIUM 24HR

Products Affected
- nexium 24hr oral capsule delayed release

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

NexIUM 24HR

Products Affected
- nexium 24hr oral tablet delayed release

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

NexIUM 24HR Clear Minis

Products Affected
- nexium 24hr clear minis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Nicorelief

Products Affected

- *nicorelief mouth/throat gum 2 mg*

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

Nicotine

Products Affected
- *nicotine*

QL Criteria	180 day supply Per 365 Days
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*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 15, 2019

Nicotine Step 1

Products Affected
- *nicotine step 1*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotine Step 2

Products Affected
- *nicotine step 2*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotine Step 3

Products Affected
- *nicotine step 3*

QL Criteria	180 day supply Per 365 Days
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	180 day supply Per 365 Days
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	180 day supply Per 365 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 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NIFEdipine ER

Products Affected

- *nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg*

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

NIFEdipine ER

Products Affected

- *nifedipine er oral tablet extended release 24 hour 60 mg*

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

NIFEdipine ER Osmotic Release

Products Affected

- *nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 90 mg*

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

NIFEdipine ER Osmotic Release

Products Affected

- *nifedipine er osmotic release oral tablet extended release 24 hour 60 mg*

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

Ninlaro

Products Affected
- ninlaro

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 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 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hour 30 mg*

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

Nitisinone

Products Affected
- *nitisinone*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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 nasal emulsion 1.66 mcg/0.1ml

QL Criteria	1 bottle Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 28, 2019

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: March 16, 2018

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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/2019/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/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Northera

Products Affected
- northera oral capsule 100 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/Northera.html
QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Northera

Products Affected
- northera oral capsule 200 mg, 300 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/Northera.html
QL Criteria	6 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Norvir

Products Affected
- norvir oral packet

QL Criteria	12 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Norvir

Products Affected
- norvir oral solution

QL Criteria	2 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

Norvir

Products Affected
- norvir oral tablet

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

Novoeight

Products Affected

- novoeight intravenous solution reconstituted 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucala

Products Affected

- nucala subcutaneous solution reconstituted

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/RESP/nucala.html
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 24, 2018 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: February 23, 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: February 23, 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: February 23, 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 duloxetine or pregablin.
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: September 08, 2019 Quantity Limits: August 25, 2015

Nuedexta

Products Affected
- nuedexta

PA Criteria	Criteria Details
Covered Uses	Treatment of pseudobulbar affect in patients with amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS).
Exclusion Criteria	Treatment in other types of emotional lability (i.e. Alzheimers disease and other dementias).
Required Medical Information	A documented diagnosis of pseudobulbar affect in patients with ALS or MS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of pseudobulbar affect in patients with ALS or MS AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 07, 2018

Nutropin AQ NuSpin 10

Products Affected
- nutropin aq nuspin 10

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Nuvigil

Products Affected
- nuvigil

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

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuzyra

Products Affected
- nuzyra oral tablet 150 mg

PA Criteria	Criteria Details
Covered Uses	NUZYRA is a tetracycline class antibacterial indicated for the treatment of adult patients with the following infections caused by susceptible microorganisms: Community-acquired bacterial pneumonia (CABP) or Acute bacterial skin and skin structure infections (ABSSSI).
Exclusion Criteria	NUZYRA is contraindicated in patients with known hypersensitivity to omadacycline or tetracycline-class antibacterial drugs, or to any of the excipients.

PA Criteria	Criteria Details
Required Medical Information	1. Community-Acquired Bacterial Pneumonia (CABP) NUZYRA is indicated for the treatment of adult patients with community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible isolates), Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamydophila pneumoniae. 2. Acute Bacterial Skin and Skin Structure Infections (ABSSSI) NUZYRA is indicated for the treatment of adult patients with acute bacterial skin and skin structure infections (ABSSSI) caused by the following susceptible microorganisms: Staphylococcus aureus (methicillin-susceptible and -resistant isolates), Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosus grp. (includes S. anginosus, S. intermedius, and S. constellatus), Enterococcus faecalis, Enterobacter cloacae, and Klebsiella pneumoniae. To reduce the development of drug-resistant bacteria and maintain the effectiveness of NUZYRA and other antibacterial drugs, NUZYRA should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy. Pertinent culture and sensitivity results should be documented and submitted, if available. Approve continuation of therapy initiated in the hospital with quantity sufficient to complete the treatment course.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 07, 2019 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: June 28, 2019

Nystatin-Triamcinolone

Products Affected

- *nystatin-triamcinolone external cream*

QL Criteria	60 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

Ocaliva

Products Affected
- ocaliva

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Primary_Biliary_Cholangitis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Primary_Biliary_Cholangitis.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: June 18, 2019

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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Odactra

Products Affected
- odactra

PA Criteria	Criteria Details
Covered Uses	House dust mite induced allergic rhinitis with or without conjunctivitis in patients 18 through 65 years of age.
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of severe local reaction to sublingual allergen immunotherapy.
Required Medical Information	A documented diagnosis of house dust mite induced allergic rhinitis with or without conjunctivitis in patients 18 through 65 years of age, confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, or skin testing to licensed house dust mite allergen extracts.
Age Restrictions	18 through 65 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 13, 2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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/2019/ANEOP/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: March 01, 2019 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/2019/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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: April 09, 2018

OLANZapine

Products Affected

- *olanzapine oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg*
- *olanzapine oral tablet dispersible 15 mg, 20 mg, 5 mg*

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

OLANZapine

Products Affected

- *olanzapine oral tablet 2.5 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: 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, 6-25 mg, 6-50 mg*

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

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl oral capsule 12-50 mg*

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

Olmesartan Medoxomil

Products Affected

- *olmesartan medoxomil oral*

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

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 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/2019/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/2019/MUSC/Olumiant.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: July 17, 2018

Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

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

Omeprazole

Products Affected

- *omeprazole oral capsule delayed release*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Omeprazole-Sodium Bicarbonate

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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

Omniflex Diaphragm

Products Affected
- omniflex diaphragm

QL Criteria	1 diaphragm Per 1 year
Notes/ References	
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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OneTouch Ultra Blue

Products Affected
- onetouch ultra blue

QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opsumit

Products Affected
- opsumit

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oralair

Products Affected
- oralair

PA Criteria	Criteria Details
Covered Uses	Grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of any severe systemic allergic reaction, history of severe local reaction to sublingual allergen immunotherapy.
Required Medical Information	A documented diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age confirmation with either a positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product (sweet vernal, orchard, perennial rye, timothy or Kentucky blue grass mixed pollens).
Age Restrictions	10 through 65 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 25, 2015

Oralair Adult Sample Kit

Products Affected
- oralair adult sample kit

PA Criteria	Criteria Details
Covered Uses	Grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of any severe systemic allergic reaction, history of severe local reaction to sublingual allergen immunotherapy.
Required Medical Information	A documented diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age confirmation with either a positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product (sweet vernal, orchard, perennial rye, timothy or Kentucky blue grass mixed pollens).
Age Restrictions	10 through 65 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 13, 2018

Oralair Adult Starter Pack

Products Affected
- oralair adult starter pack

PA Criteria	Criteria Details
Covered Uses	Grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of any severe systemic allergic reaction, history of severe local reaction to sublingual allergen immunotherapy.
Required Medical Information	A documented diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age confirmation with either a positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product (sweet vernal, orchard, perennial rye, timothy or Kentucky blue grass mixed pollens).
Age Restrictions	10 through 65 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 25, 2015

Oralair Childrens Sample Kit

Products Affected
- oralair childrens sample kit

PA Criteria	Criteria Details
Covered Uses	Grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of any severe systemic allergic reaction, history of severe local reaction to sublingual allergen immunotherapy.
Required Medical Information	A documented diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age confirmation with either a positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product (sweet vernal, orchard, perennial rye, timothy or Kentucky blue grass mixed pollens).
Age Restrictions	10 through 65 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 13, 2018

Oralair Childrens Starter Pack

Products Affected
- oralair childrens starter pack

PA Criteria	Criteria Details
Covered Uses	Grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of any severe systemic allergic reaction, history of severe local reaction to sublingual allergen immunotherapy.
Required Medical Information	A documented diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10 through 65 years of age confirmation with either a positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product (sweet vernal, orchard, perennial rye, timothy or Kentucky blue grass mixed pollens).
Age Restrictions	10 through 65 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 25, 2015

Oravig

Products Affected
- oravig

QL Criteria	14 tablets Per 1 fill
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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/2019/MUSC/Orencia.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Orencia.html
QL Criteria	4 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Orenitram

Products Affected
- orenitram

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 07, 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 07, 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 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/2019/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 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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 24, 2018 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 12, 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/2019/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/2019/MUSC/Otezla.html
QL Criteria	2 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Otezla.html
QL Criteria	1 KIT Per 365 DAYSs
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/MUSC/Otrexup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxervate

Products Affected
- oxervate

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 mls Per 1 day and 112 mls per lifetime
Notes/ References	
Revision Date	Prior Authorization: September 24, 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

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

Oxtellar XR

Products Affected

- oxtellar xr oral tablet extended release 24 hour 600 mg

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

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 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

oxyCODONE HCl

Products Affected

- *oxycodone 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl

Products Affected

- *oxycodone 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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.
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.
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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

oxyCODONE-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral tablet 5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxycodone-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral tablet 2.5-325 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 25, 2015

Ozempic (0.25 or 0.5 MG/DOSE)

Products Affected
- ozempic (0.25 or 0.5 mg/dose)

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Not indicated for use in type 1 diabetes mellitus or treatment of diabetic ketoacidosis, if member has pancreatitis, in patients with a personal or family history of medullary thyroid carcinoma or in patients with multiple endocrine neoplasia syndrome, or for members with type 2 and known hypersensitivity to Ozempic or any of the product components.
Required Medical Information	Member must have a HbA1c greater than or equal to 6.5%, documentation of type 2 diabetes, and is requesting the medication in use as adjunctive to diet and exercise.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Metformin/XR
QL Criteria	1 pen Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: June 06, 2019 Quantity Limits: August 25, 2015

Ozempic (1 MG/DOSE)

Products Affected
- ozempic (1 mg/dose)

PA Criteria	Criteria Details
Covered Uses	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Exclusion Criteria	Not indicated for use in type 1 diabetes mellitus or treatment of diabetic ketoacidosis, if member has pancreatitis, in patients with a personal or family history of medullary thyroid carcinoma or in patients with multiple endocrine neoplasia syndrome, or for members with type 2 and known hypersensitivity to Ozempic or any of the product components.
Required Medical Information	Member must have a HbA1c greater than or equal to 6.5%, documentation of type 2 diabetes, and is requesting the medication in use as adjunctive to diet and exercise.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Metformin/XR
QL Criteria	2 pens Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: January 22, 2018 Step Therapy: June 06, 2019 Quantity Limits: June 28, 2019

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/2019/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/2019/MISC/metabolic_agents.html
QL Criteria	1 syringe Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: July 16, 2018

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

Pantoprazole Sodium

Products Affected

- *pantoprazole sodium oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 tablet per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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 tablet 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 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 37.5 mg*

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hour 25 mg*

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

PARoxetine Mesylate

Products Affected

- *paroxetine mesylate*

PA Criteria	Criteria Details
Covered Uses	Moderate to severe vasomotor symptoms associated with menopause
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paxil

Products Affected
- paxil oral suspension

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

Paxil

Products Affected
- paxil oral tablet 10 mg, 20 mg

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

Paxil

Products Affected
- paxil oral tablet 30 mg, 40 mg

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

Paxil CR

Products Affected

- paxil cr oral tablet extended release 24 hour 12.5 mg

QL Criteria	6 tabs Per 1 DAYS
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 oral tablet extended release 24 hour 25 mg

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

Paxil CR

Products Affected

- paxil cr oral tablet extended release 24 hour 37.5 mg

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

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/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pegasys ProClick

Products Affected

- pegasys proclick subcutaneous solution 180 mcg/0.5ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

penicillAMINE

Products Affected
- *penicillamine oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 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

Pentasa

Products Affected

- pentasa oral capsule extended release 250 mg

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

Pentasa

Products Affected

- pentasa oral capsule extended release 500 mg

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

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 Striverdi (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	4 milliliters Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 06, 2019 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: June 19, 2018

Pifeltro

Products Affected
- pifeltro

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

Pimecrolimus

Products Affected
- *pimecrolimus*

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 med/high topical steroid. such as triamcinolone acetonide, betamethasone dipropionate
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 07, 2019 Quantity Limits: August 25, 2015

Pioglitazone HCl

Products Affected
- *pioglitazone hcl*

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

Pioglitazone HCl-Glimepiride

Products Affected
- *pioglitazone hcl-glimepiride*

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

Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-metformin hcl*

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

Piqray (200 MG Daily Dose)

Products Affected
- piqray (200 mg daily dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/piqray.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 15, 2019

Piqray (250 MG Daily Dose)

Products Affected
- piqray (250 mg daily dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/piqray.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin for details
Other Criteria	
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

Piqray (300 MG Daily Dose)

Products Affected
- piqray (300 mg daily dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/piqray.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin for details
Other Criteria	
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

Plavix

Products Affected
- plavix oral tablet 75 mg

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

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/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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: September 24, 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/2019/ANEOP/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 1 month
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

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

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

Praluent

Products Affected

- praluent 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/2019/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/2019/MISC/PCSK9.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: November 14, 2019

Pramipexole Dihydrochloride ER

Products Affected

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

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

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

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

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: May 08, 2019

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

Prevacid 24HR

Products Affected
- prevacid 24hr

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: January 09, 2018

Prezcobix

Products Affected
- prezcobix

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

Prezista

Products Affected
- prezista oral suspension

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

Prezista

Products Affected
- prezista oral tablet 150 mg, 600 mg, 75 mg

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

Prezista

Products Affected
- prezista oral tablet 800 mg

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

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/2019/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/2019/MISC/ivig.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Procardia XL

Products Affected

- procardia xl oral tablet extended release 24 hour 30 mg

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

Procardia XL

Products Affected

- procardia xl oral tablet extended release 24 hour 60 mg, 90 mg

QL Criteria	2 TB24 Per 1 DAYS
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 milliliters Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Erythropoiesis_Stimulating_Agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/ENDO/lysosomal_storage.html
QL Criteria	8 CAP Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/ENDO/lysosomal_storage.html
QL Criteria	25 CAP Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Profilnine

Products Affected
- profilnine

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Progesterone Micronized

Products Affected

- *progesterone micronized oral*

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

Prolastin-C

Products Affected

- prolastin-c intravenous solution reconstituted 1000 mg
- prolastin-c intravenous solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected
- promacta oral packet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/thrombopoietin_receptor_agonists.html
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 packet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected

- promacta oral tablet 12.5 mg, 25 mg, 50 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/thrombopoietin_receptor_agonists.html
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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected
- promacta oral tablet 75 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/thrombopoietin_receptor_agonists.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prometrium

Products Affected
- prometrium

QL Criteria	2 CAPS Per 1 DAYS
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

Provigil

Products Affected
- provigil oral tablet 100 mg

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

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

Provigil

Products Affected
- provigil oral tablet 200 mg

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

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

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

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/2019/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ampules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/ANEOP/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: January 14, 2019 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: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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

Qtern

Products Affected
- qtern oral tablet 10-5 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Metformin/XR
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 08, 2019 Quantity Limits: September 09, 2019

Qtern

Products Affected
- qtern oral tablet 5-5 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Metformin/XR
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 08, 2019 Quantity Limits: September 10, 2019

Qudexy XR

Products Affected

- qudexy xr oral capsule er 24 hour sprinkle
  100 mg, 25 mg, 50 mg

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

Qudexy XR

Products Affected

- qudexy xr oral capsule er 24 hour sprinkle
  150 mg, 200 mg

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

QUEtiapine Fumarate

Products Affected

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

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 300 mg, 400 mg*

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

QUEtiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg*

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

QUEtiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 300 mg*

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

QUEtiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 400 mg, 50 mg*

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

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

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

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	12 milliliters Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

RA Nicotine

Products Affected

- *ra nicotine transdermal*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RABEprazole Sodium

Products Affected

- *rabeprazole sodium oral capsule sprinkle*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
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)
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: October 05, 2019 Quantity Limits: October 08, 2019

RABEprazole Sodium

Products Affected

- *rabeprazole sodium oral tablet delayed release*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 tablet per day, 90 day supply Per 365 Days
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Ragwitek

Products Affected
- ragwitek

PA Criteria	Criteria Details
Covered Uses	Grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 18 through 65 years of age.
Exclusion Criteria	Severe, unstable, or uncontrolled asthma (rescue inhaler use greater than 2 days or more per week; significantly impaired activity levels due to symptoms), eosinophilic esophagitis, history of any severe systemic allergic reaction, history of severe local reaction to sublingual allergen immunotherapy.
Required Medical Information	A documented diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 18 through 65 years of age, confirmation with either a positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragwitek grass pollen.
Age Restrictions	18 through 65 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 antihistamines (i.e. Claritin OTC, Zyrtec OTC, or Allegra OTC).
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 13, 2018 Quantity Limits: August 13, 2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Ranolazine ER

Products Affected
- *ranolazine er*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 05, 2019

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/2019/MUSC/Otrexup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/metabolic_agents.html
QL Criteria	20 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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 capsules Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: December 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rayos

Products Affected
- rayos

ST Criteria	A documented contraindication, intolerance, allergy, or failure of prednisone
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Razadyne

Products Affected
- razadyne oral tablet 4 mg, 8 mg

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/2019/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 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/2019/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 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/2019/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 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/2019/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rectiv

Products Affected
- rectiv

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

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: March 03, 2019

Relenza Diskhaler

Products Affected
- relenza diskhaler

QL Criteria	40 disks Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 07, 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

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

Remeron

Products Affected
- remeron oral tablet 15 mg, 30 mg

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

Remeron SolTab

Products Affected
- remeron soltab

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

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/2019/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/2019/MUSC/Remicade.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Renflexis.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/PCSK9.html
QL Criteria	2 units Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/PCSK9.html
QL Criteria	1 syringe Per 30 days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/PCSK9.html
QL Criteria	2 units Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Requip XL

Products Affected

- requip xl oral tablet extended release 24 hour 4 mg, 8 mg

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

Rescriptor

Products Affected
- rescriptor oral tablet 200 mg

QL Criteria	15 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Restoril

Products Affected
- restoril oral capsule 22.5 mg, 7.5 mg

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

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/2019/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 24, 2018 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 and 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	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin and Epiduo
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: March 13, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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 and 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	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin and Epiduo
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: March 13, 2019 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 and 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	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin and Epiduo
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: March 13, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Retrovir

Products Affected
- retrovir oral capsule

QL Criteria	6 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Retrovir

Products Affected
- retrovir oral syrup

QL Criteria	8 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Revatio

Products Affected
- revatio intravenous

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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 clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/pulmonaryhypertensionagents.html
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Revatio

Products Affected
- revatio oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/pulmonaryhypertensionagents.html
QL Criteria	3 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: September 24, 2018 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/2019/ANEOP/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: January 14, 2019 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 A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER). FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Reyataz

Products Affected
- reyataz oral capsule 150 mg, 300 mg

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

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 packet

QL Criteria	6 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

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/2019/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 24, 2018 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*

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

Risedronate Sodium

Products Affected

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

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

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 35 mg* *release*
- *risedronate sodium oral tablet delayed*

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

RisperDAL

Products Affected
- risperdal oral solution

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Autistic Disorder, Bipolar Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole OR risperidone).
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- risperdal oral tablet 0.5 mg, 1 mg, 2 mg, 3 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Autistic Disorder, Bipolar Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Autistic Disorder, or Bipolar Disorder AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole OR risperidone).
QL Criteria	2 tabs Per 1 DAYS

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 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 SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF AUTISTIC DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole OR risperidone).
QL Criteria	4 tabs Per 1 DAYS
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

risperiDONE

Products Affected

- *risperidone oral tablet 2 mg*

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

risperiDONE

Products Affected

- *risperidone oral tablet 4 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg*
- *risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet 3 mg*
- *risperidone oral tablet dispersible 3 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet dispersible 4 mg*

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

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 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

Ritalin LA

Products Affected

- ritalin la oral capsule extended release 24 hour 10 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 CAPS Per 1 DAYS
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 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 CAPS Per 1 DAYS
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

Ritonavir

Products Affected
- *ritonavir*

QL Criteria	12 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

Rituxan

Products Affected
- rituxan intravenous solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Rituxan.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Rituxan.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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 24, 2018 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: August 25, 2015

rocklatan

Products Affected
- rocklatan

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

ROPINIRole HCl ER

Products Affected

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

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

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release 24 hour 2 mg, 4 mg, 6 mg, 8 mg*

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

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

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

Roxicodone

Products Affected
- roxicodone oral tablet 15 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rubraca

Products Affected
- rubraca 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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: June 28, 2019

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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rubraca

Products Affected
- rubraca 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/2019/ANEOP/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: March 01, 2019 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/2019/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	8 vials Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rythmol SR

Products Affected
- rythmol sr

QL Criteria	2 CP12 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2019/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/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sancuso

Products Affected
- sancuso

QL Criteria	1 patch Per 1 month
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 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/2019/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 24, 2018 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	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone).
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 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	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone).
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 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: August 25, 2015

Savella

Products Affected
- savella

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of duloxetine or pregabalin
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 05, 2019 Quantity Limits: August 25, 2015

Savella Titration Pack

Products Affected
- savella titration pack

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of duloxetine or pregabalin
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 05, 2019 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 23, 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, 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

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 300 mg

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

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	Members with a serum calcium level less than the lower limit of the normal range
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: February 07, 2019 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 SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, or quetiapine).
QL Criteria	3 tabs Per 1 DAYS

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 21, 2018 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 SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, or quetiapine).
QL Criteria	4 tabs Per 1 DAYS

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 21, 2018 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 SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, or quetiapine).
QL Criteria	6 tabs Per 1 DAYS

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

SEROquel

Products Affected
- seroquel oral tablet 300 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Depressive episodes associated with bipolar disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A Documented diagnosis of Schizophrenia, Bipolar Disorder, or depressive episodes associated with bipolar disorder AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, or quetiapine).
QL Criteria	2 tabs Per 1 DAYS

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- seroquel xr oral tablet extended release 24 hour 150 mg, 200 mg

PA Criteria	Criteria Details
Covered Uses	Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, and Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, or Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, OR quetiapine).
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- seroquel xr oral tablet extended release 24 hour 300 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, and Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, or Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, OR quetiapine).
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- seroquel xr oral tablet extended release 24 hour 50 mg

PA Criteria	Criteria Details
Covered Uses	Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, and Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of Bipolar Disorder, Bipolar Depression, Major Depressive Disorder, or Schizophrenia AND There is clinical documentation indicating disease stability or improvement from baseline

ST Criteria	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole or quetiapine ER). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, OR quetiapine).
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

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

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/2019/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 SOLN Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: October 22, 2018

Siklos

Products Affected
- siklos

PA Criteria	Criteria Details
Covered Uses	Sickle cell anemia with recurrent moderate to severe painful crises
Exclusion Criteria	
Required Medical Information	For ages 19 years or greater, the following criteria must be met: A documented diagnosis of sickle cell anemia with recurrent moderate to severe painful crises and a documented 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 clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 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/2019/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/2019/MUSC/Siliq.html
QL Criteria	2 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Simponi.html
QL Criteria	1 syringe Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Simponi Aria.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Simvastatin

Products Affected
- *simvastatin oral*

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

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/2019/ID/sirturo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	188 EA Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sivextro

Products Affected
- sivextro oral

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

SM Nicotine

Products Affected

- *sm nicotine transdermal*

QL Criteria	180 day supply Per 365 Days
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*
- *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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Solia

Products Affected

- *solia*

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

Solifenacin Succinate

Products Affected

- *solifenacin succinate*

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

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 23, 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/2019/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 24, 2018 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/2019/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 24, 2018 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 23, 2018 Quantity Limits: August 25, 2015

Soriatane

Products Affected
- soriatane oral capsule 10 mg, 25 mg

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

Sovaldi

Products Affected
- sovaldi 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/2019/GI/Sovaldi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: September 24, 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

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

Spiriva Respimat

Products Affected

- spiriva respimat inhalation aerosol solution 2.5 mcg/act

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

Sporanox

Products Affected
- sporanox oral capsule

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

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/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: August 25, 2015

Sprycel

Products Affected
- sprycel 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/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: March 19, 2019

Sprycel

Products Affected
- sprycel oral tablet 50 mg, 70 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: August 25, 2015

Sprycel

Products Affected
- sprycel oral tablet 80 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: August 25, 2015

Stavudine

Products Affected

- *stavudine 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: June 12, 2019

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/2019/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/2019/MUSC/Stelara.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MUSC/Stelara.html
QL Criteria	2 vials Per 90 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 13, 2018

Stelara

Products Affected

- stelara subcutaneous solution prefilled syringe 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/2019/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/2019/MUSC/Stelara.html
QL Criteria	2 syringes Per 90 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Stelara

Products Affected

- stelara subcutaneous solution prefilled syringe 90 mg/ml

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MUSC/Stelara.html
QL Criteria	2 syringes Per 60 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/ANEOP/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	84 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

Strattera

Products Affected

- strattera oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	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

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/2019/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 24, 2018 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/2019/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ID/antiviral_hiv.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Striverdi Respimat

Products Affected
- striverdi respimat

QL Criteria	1 inhaler Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 14, 2019

Sular

Products Affected

- sular oral tablet extended release 24 hour
  17 mg, 34 mg, 8.5 mg

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

SulfaSALAzine

Products Affected

- *sulfasalazine oral*

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

Sulfazine

Products Affected
- *sulfazine*

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

SUMAtriptan

Products Affected

- *sumatriptan nasal*

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

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: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml*

QL Criteria	10 cart/30 day Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill subcutaneous solution cartridge*

QL Criteria	10 cart/30 day Per 48 max in 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Supartz FX

Products Affected
- supartz fx

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Sustiva

Products Affected
- sustiva oral capsule

QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Sustiva

Products Affected
- sustiva 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: June 13, 2019

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/2019/ANEOP/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: January 14, 2019 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected
- sutent oral capsule 37.5 mg, 50 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sylatron

Products Affected

- sylatron subcutaneous kit 200 mcg, 600 mcg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sylatron

Products Affected
- sylatron subcutaneous kit 300 mcg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

Symbicort

Products Affected
- symbicort

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

Symbyax

Products Affected

- symbyax oral capsule 12-50 mg, 6-25 mg, 6-50 mg

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

Symdeko

Products Affected

- symdeko oral tablet therapy pack 100-150 & 150 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: March 15, 2018

Symdeko

Products Affected

- symdeko oral tablet therapy pack 50-75 & 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 08, 2019

Symfi

Products Affected
- symfi

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

Symfi Lo

Products Affected
- symfi lo

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

Symjepi

Products Affected

- symjepi injection solution prefilled syringe 0.3 mg/0.3ml

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

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

Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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/2019/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ID/antiviral_hiv.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 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/2019/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 24, 2018 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

PA Criteria	Criteria Details
Covered Uses	For use on intact skin in patients 3 years and older to provide local analgesia for superficial venous access and superficial dermatological procedures, including excision, electrodesiccation, and shave biopsy of skin lesions.
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 to provide local analgesia for superficial venous access and superficial dermatological procedures, including excision, electrodesiccation, and shave biopsy of skin lesions. Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of ongoing need for topical local analgesia.
Age Restrictions	Adults and children 3 years and older
Prescriber Restrictions	
Coverage Duration	3 months

PA Criteria	Criteria Details
Other Criteria	Topical lidocaine/tetracaine cream is used for temporary anesthesia. ***AUTHORIZATION IS NOT REQUIRED FOR 10 Patches OR LESS OF LIDOCAINE/TETRACAINE EVERY 30 DAYS*** For quantities over 10 patches every 30 days, there must be a documented temporary need for topical anesthetic in either of the following situations: to provide topical local analgesia for superficial dermatological procedures such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Renewal Duration: 3 months *Up to an additional 10 patches per 30 days. Due to Safety Concerns higher quantities and prolonged use are not recommended.
QL Criteria	10 patches Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 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

Synribo

Products Affected
- synribo

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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/2019/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 24, 2018 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	

Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 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 clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Take Action

Products Affected
- *take action*

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

Takhzyro

Products Affected
- takhzyro

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: September 24, 2018 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/2019/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/2019/MUSC/Taltz.html
QL Criteria	1 syringe Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: June 17, 2019

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/2019/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/2019/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

Tarceva

Products Affected
- tarceva oral tablet 100 mg, 150 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tarceva

Products Affected
- tarceva 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Targretin

Products Affected
- targretin external

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: March 01, 2019 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/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 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/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	4 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: May 16, 2018

Tavalisse

Products Affected
- tavalisse

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2018

Tazarotene

Products Affected
- *tazarotene external*

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris, plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris or plaque psoriasis
Age Restrictions	Prior authorization only required in patients older than 35 years of age.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: April 04, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Taztia XT

Products Affected

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

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

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/2019/CNS/Tecfidera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tegsedi

Products Affected
- tegsedi

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2018/MISC/tegsedi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tekturna HCT

Products Affected
- tekturna hct

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic aliskiren and 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 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: April 08, 2019 Quantity Limits: August 25, 2015

Telmisartan

Products Affected
- *telmisartan*

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

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 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Telmisartan-HCTZ

Products Affected
- *telmisartan-hctz*

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

Temazepam

Products Affected

- *temazepam oral capsule 22.5 mg, 7.5 mg*

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

Temixys

Products Affected
- temixys

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, 2019

Temovate

Products Affected
- temovate external cream

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

Temozolomide

Products Affected
- *temozolomide*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 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 17, 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%), 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%)*

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

QL Criteria	5 grams Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: November 10, 2018 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
QL Criteria	6 ml Per 1 day
Notes/ References	Annual Review: 07/2018

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TGT Nicotine Step One

Products Affected

- *tgt nicotine step one*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TGT Nicotine Step Three

Products Affected

- *tgt nicotine step three*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TGT Nicotine Step Two

Products Affected

- *tgt nicotine step two*

QL Criteria	180 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thalomid

Products Affected
- thalomid

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thiola EC

Products Affected
- thiola ec

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thrive

Products Affected

- *thrive mouth/throat gum 2 mg*

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 12 mg, 4 mg*

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 16 mg*

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 2 mg*

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

Tiazac

Products Affected

- tiazac oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg, 420 mg

QL Criteria	1 CP24 Per 1 DAYS
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 CP24 Per 1 DAYS
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/2019/ANEOP/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: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 07, 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 DAYS
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	10 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

Tobi Podhaler

Products Affected
- tobi podhaler

QL Criteria	1 CAPS 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	10 ml Per 1 day
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 capsule 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 CPSP Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Topicort

Products Affected
- topicort external ointment 0.25 %

QL Criteria	120 grams Per 1 month
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 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Tracleer

Products Affected
- tracleer oral tablet soluble

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tranexamic Acid

Products Affected
- *tranexamic acid oral*

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tremfya

Products Affected

- tremfya 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/2019/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/2019/MUSC/Tremfya.html
QL Criteria	1 injection Per 8 weeks
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Tremfya

Products Affected

- tremfya 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/2019/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/2019/MUSC/Tremfya.html
QL Criteria	1 injection Per 56 days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Treprostinil

Products Affected
- *treprostinil*

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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 and 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	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: March 13, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 and 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	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: March 13, 2019 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 and 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	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: March 13, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triamcinolone Acetonide

Products Affected

- *triamcinolone acetonide external cream 0.1 %*

QL Criteria	60 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triamcinolone Acetonide

Products Affected

- *triamcinolone acetonide external ointment 0.1 %*

QL Criteria	60 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 17, 2019

Triamcinolone Acetonide

Products Affected

- *triamcinolone acetonide nasal aerosol*

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

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 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Tricor

Products Affected
- tricor

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

Triderm

Products Affected

- *triderm external cream 0.1 %*

QL Criteria	60 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trientine HCl

Products Affected
- *trientine hcl*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trilipix

Products Affected
- trilipix

QL Criteria	1 CPDR Per 1 DAYS
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

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triumeq

Products Affected
- triumeq

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

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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Trizivir

Products Affected
- trizivir

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

Trokendi XR

Products Affected

- trokendi xr oral capsule extended release 24 hour 100 mg, 25 mg, 50 mg

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

Trokendi XR

Products Affected

- trokendi xr oral capsule extended release 24 hour 200 mg

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

Trospium Chloride

Products Affected
- *trospium chloride*

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

Trospium Chloride ER

Products Affected

- *trospium chloride er*

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

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

Truvada

Products Affected
- truvada

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

Tudorza Pressair

Products Affected

- tudorza pressair inhalation aerosol powder breath activated 400 mcg/act

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 23, 2018 Quantity Limits: August 25, 2015

TussiCaps

Products Affected

- tussicaps oral capsule extended release 12 hour 10-8 mg

PA Criteria	Criteria Details
Covered Uses	The member is aged 18 years or older AND The member does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30) AND The member has tried and failed at least one non-opioid containing cough and cold remedy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	adults (18 years or older)
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
QL Criteria	2 capsules per day, max 20 Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: April 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: June 18, 2019

Tuxarin ER

Products Affected
- tuxarin er

PA Criteria	Criteria Details
Covered Uses	The member is aged 18 years or older AND The member does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30) AND The member has tried and failed at least one non-opioid containing cough and cold remedy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	adults (18 years or older)
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
QL Criteria	2 tablets Per 1 day max 20 tablets per 30 day
Notes/ References	
Revision Date	Prior Authorization: April 01, 2019 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 tabs Per 1 DAYS
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: February 23, 2018 Quantity Limits: August 25, 2015

Tybost

Products Affected
- tybost

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

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/2019/ANEOP/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	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: March 19, 2019

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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/2019/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/2019/MUSC/bone_disease_agents.html
QL Criteria	1 pen Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/CNS/Tysabri.html
QL Criteria	1 vial Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: June 17, 2019

Tyvaso

Products Affected
- tyvaso

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 SOLN Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyvaso Refill

Products Affected
- tyvaso refill

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyvaso Starter

Products Affected
- tyvaso starter

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 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, Delzicol, or Pentasa.
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 05, 2019 Quantity Limits: August 25, 2015

Uceris

Products Affected
- uceris rectal

PA Criteria	Criteria Details
Covered Uses	Active mild to moderate ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of ACTIVE mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge, requiring induction of remission.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of mild to moderate ulcerative colitis AND There is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	2 canisters Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Udenyca

Products Affected
- udenyca

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 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

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultravate

Products Affected
- ultravate external lotion

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

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 clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uptravi

Products Affected

- uptravi oral tablet 200 mcg
- uptravi oral tablet therapy pack

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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 23, 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/ID/valcyte.html
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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/ID/valcyte.html
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 EA Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/ID/valcyte.html
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 24, 2018 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/2019/ID/valcyte.html
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 24, 2018 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 tablet 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

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

Vecamyl

Products Affected
- vecamyl

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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/2019/CV/antihypertensive_misc.html
QL Criteria	10 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Veletri

Products Affected
- veletri

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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).

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month of sodium polystyrene sulfonate
QL Criteria	1 packet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 24, 2017 Step Therapy: March 05, 2019 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/2019/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/2019/GI/Vemlidy.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/ANEOP/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: March 01, 2019 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/2019/ANEOP/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	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 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/2019/ANEOP/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: March 01, 2019 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/2019/ANEOP/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: March 01, 2019 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 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hour 225 mg*

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

Ventavis

Products Affected
- ventavis

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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: April 08, 2019 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 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

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

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	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF SCHIZOAFFECTIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (palilperidone ER OR clozapine).
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 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/2019/ANEOP/Verzenio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: November 09, 2017

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 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 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: August 25, 2015

Videx

Products Affected
- videx oral solution reconstituted 2 gm

QL Criteria	12 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Videx EC

Products Affected

- videx ec oral capsule delayed release 125 mg, 200 mg, 250 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

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/2019/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/2019/GI/Viekira.html
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Vigabatrin

Products Affected
- *vigabatrin oral packet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vigabatrin

Products Affected
- *vigabatrin oral tablet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: July 17, 2018

Viibryd

Products Affected
- viibryd oral tablet

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

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected
- vimpat oral solution

QL Criteria	40 ML Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected
- vimpat oral tablet

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

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

Viracept

Products Affected
- viracept oral tablet 250 mg

QL Criteria	10 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

Viracept

Products Affected
- viracept oral tablet 625 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

Viramune

Products Affected
- viramune oral suspension

QL Criteria	5 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Viramune

Products Affected
- viramune oral tablet

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

Viramune XR

Products Affected

- viramune xr oral tablet extended release 24 hour 400 mg

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

Viread

Products Affected
- viread oral powder

QL Criteria	4 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Viread

Products Affected
- viread oral tablet

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

Visco-3

Products Affected

- visco-3 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/2019/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/2019/MISC/viscosupplements.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vitrakvi

Products Affected
- vitrakvi oral capsule 100 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/vitrakvi.html
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: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vitrakvi

Products Affected
- vitrakvi 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/vitrakvi.html
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: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vitrakvi

Products Affected
- vitrakvi oral solution

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/vitrakvi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	10 ml Per 1 day
Notes/ References	
Revision Date	Prior Authorization: December 12, 2018 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/2019/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

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/2019/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 24, 2018 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/2019/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: September 24, 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/2019/ANEOP/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: January 14, 2019 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/2019/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 24, 2018 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 antipsychotic (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	4 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

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 antipsychotic (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	2 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 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 antipsychotic (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 07/2018

Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 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 antipsychotic (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 21, 2018 Quantity Limits: August 25, 2015

Vytorin

Products Affected
- vytorin

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic simvastatin in combination with generic ezetimibe, or generic ezetimibe-simvastatin
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

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

Wide-Seal Diaphragm 60

Products Affected
- wide-seal diaphragm 60

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

Wide-Seal Diaphragm 65

Products Affected
- wide-seal diaphragm 65

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

Wide-Seal Diaphragm 70

Products Affected
- wide-seal diaphragm 70

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

Wide-Seal Diaphragm 75

Products Affected
- wide-seal diaphragm 75

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

Wide-Seal Diaphragm 80

Products Affected
- wide-seal diaphragm 80

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

Wide-Seal Diaphragm 85

Products Affected
- wide-seal diaphragm 85

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

Wide-Seal Diaphragm 90

Products Affected
- wide-seal diaphragm 90

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

Wide-Seal Diaphragm 95

Products Affected
- wide-seal diaphragm 95

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

Wixela Inhub

Products Affected
- wixela inhub

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

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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto

Products Affected
- xarelto oral tablet 10 mg, 20 mg

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

Xarelto

Products Affected
- xarelto oral tablet 15 mg

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

Xarelto

Products Affected
- xarelto oral tablet 2.5 mg

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

Xarelto Starter Pack

Products Affected
- xarelto starter pack

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

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Xeljanz_XlejanzXR.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/2019/MUSC/Xeljanz_XlejanzXR.html
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: July 17, 2018

Xeljanz XR

Products Affected
- xeljanz xr

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Xeljanz_XlejanzXR.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/2019/MUSC/Xeljanz_XlejanzXR.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Xelpros

Products Affected
- xelpros

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, allergy, intolerance or failure of 1 week trial of Travatan Z
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: December 12, 2018 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/2019/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/2019/MISC/xenazine.html
QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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/2019/MISC/xenazine.html
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/2019/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 24, 2018 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/2019/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 24, 2018 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/2019/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/2019/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Xifaxan

Products Affected
- xifaxan oral tablet 200 mg

QL Criteria	9 tablets Per 1 fill
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 12, 2018

Xigduo XR

Products Affected

- xigduo xr oral tablet extended release 24 hour 5-1000 mg

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

Xodol

Products Affected
- xodol oral tablet 5-300 mg

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 and non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, and a written/signed agreement between prescriber and; patient addressing issues of prescription management, diversion, and; the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or 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	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: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xofluza

Products Affected
- xofluza

QL Criteria	4 tablets Per 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2019/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/2019/RESP/Xolair.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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: February 23, 2018 Quantity Limits: August 25, 2015

Xospata

Products Affected
- xospata

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2018/ANEOPL/xospata.html
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: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xpovio (100 MG Once Weekly)

Products Affected
- xpovio (100 mg once weekly)

PA Criteria	Criteria Details
Covered Uses	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Other Criteria	
QL Criteria	20 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: September 11, 2019

Xpovio (60 MG Once Weekly)

Products Affected
- xpovio (60 mg once weekly)

PA Criteria	Criteria Details
Covered Uses	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Other Criteria	
QL Criteria	12 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xpovio (80 MG Once Weekly)

Products Affected
- xpovio (80 mg once weekly)

PA Criteria	Criteria Details
Covered Uses	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Other Criteria	
QL Criteria	16 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xpovio (80 MG Twice Weekly)

Products Affected
- xpovio (80 mg twice weekly)

PA Criteria	Criteria Details
Covered Uses	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/xpovio.html
Other Criteria	
QL Criteria	32 tablets Per 28 Days
Notes/ References	
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/2019/ANEOP/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/2019/ANEOP/Antineoplastics.html
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 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 23, 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyntha Solofuse

Products Affected
- xyntha solofuse intravenous kit 3000 unit

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyosted

Products Affected
- xyosted

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 generic testosterone gel
QL Criteria	4 injections Per 1 month

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: November 10, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Yervoy

Products Affected
- yervoy

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Yervoy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/2019/ANEOP/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/2019/ANEOP/Yonsa.html
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: March 01, 2019 Quantity Limits: June 18, 2018

Yupelri

Products Affected
- yupelri

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 vial Per 1 day
Notes/ References	
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: April 06, 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

Zaleplon

Products Affected
- *zaleplon*

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 16, 2019

Zaltrap

Products Affected
- zaltrap

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Zaltrap.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 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/2019/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 24, 2018 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/2019/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 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid OTC

Products Affected
- zegerid otc

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
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	Refer to the clinical policy bulletin for details
Other Criteria	
QL Criteria	1 capsule per day, 90 day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2019 Aetna Pharmacy Drug Guide - AFA Value Plus Small Group Plan
The formulary is updated the first week of each month
12/01/2019

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/2019/ANEOP/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: March 01, 2019 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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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/2019/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 24, 2018 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: August 25, 2015

Zemplar

Products Affected
- zemplar oral capsule 1 mcg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of paricalcitol and calcitriol
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: July 08, 2019

Zemplar

Products Affected
- zemplar oral capsule 2 mcg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of paricalcitol and calcitriol
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: July 08, 2019

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 tablets 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/2019/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: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zerit

Products Affected
- zerit oral capsule 30 mg

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 12, 2019

Zerit

Products Affected
- zerit oral capsule 40 mg

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

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

Ziagen

Products Affected
- ziagen oral solution

QL Criteria	4 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Ziagen

Products Affected
- ziagen oral tablet

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

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

Zidovudine

Products Affected
- *zidovudine oral capsule*

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

Zidovudine

Products Affected

- *zidovudine oral syrup*

QL Criteria	8 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 13, 2019

Zidovudine

Products Affected
- *zidovudine oral tablet*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: June 28, 2019

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

Zocor

Products Affected
- zocor

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

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/2019/ANEOP/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: January 14, 2019 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: August 25, 2015

Zoloft

Products Affected
- zoloft oral tablet 100 mg

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

Zoloft

Products Affected
- zoloft oral tablet 25 mg

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

Zoloft

Products Affected
- zoloft oral tablet 50 mg

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

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

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

Zomacton

Products Affected
- zomacton

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Zomig

Products Affected
- zomig nasal solution 2.5 mg

QL Criteria	6 sprays Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

Zomig

Products Affected
- zomig nasal solution 5 mg

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

Zomig

Products Affected
- zomig oral

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

Zomig ZMT

Products Affected
- zomig zmt

QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: January 12, 2018

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 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

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/2019/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 24, 2018 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, 11.4-2.9 mg, 2.9-0.71 mg, 5.7-1.4 mg, 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

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/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 CAP Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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

Zykadia

Products Affected
- zykadia oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 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 SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, or quetiapine).

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 21, 2018 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 SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, or quetiapine).
QL Criteria	2 tablets Per 1 Day

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 21, 2018 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	FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCL, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (olanzapine, lurasidone HCl, quetiapine ER, or quetiapine).
QL Criteria	1 tabs Per 1 DAYS

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 24, 2018 Step Therapy: August 21, 2018 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/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: December 19, 2018

Zytiga

Products Affected
- zytiga oral tablet 500 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/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: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyvox

Products Affected
- zyvox oral tablet

QL Criteria	28 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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synjardy xr oral tablet extended release 24 hour 10-1000 mg, 12.5-1000 mg, 5-1000 mg 1623
synjardy xr oral tablet extended release 24 hour 25-1000 mg 1624
synribo 1625
synvisc intra-articular solution prefilled syringe 1626
synvisc one intra-articular solution prefilled syringe 1627
syprine 1628
taclonex external suspension 1629
tacrolimus external 1630
tadalafil (pah) 1634
tadalafil oral tablet 2.5 mg, 5 mg 1632
tafinlar 1635
tagrisso 1636
take action 1637
takhzyro 1638
taltz 1639
talzenna oral capsule 0.25 mg 1640
talzenna oral capsule 1 mg 1641
tarceva oral tablet 100 mg, 150 mg 1642
tarceva oral tablet 25 mg 1643
targretin external 1644
tasigna oral capsule 150 mg, 200 mg 1645
tasigna oral capsule 50 mg 1646
tavalisse 1647
tazarotene external 1648
tazorac 1649
taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg 1650
taztia xt oral capsule extended release 24 hour 240 mg 1651
tecfidera 1652
tegsedi 1653
tekturna hct 1654
telmisartan 1655
telmisartan-amlodipine 1656
telmisartan-hctz 1657
temazepam oral capsule 22.5 mg, 7.5 mg 1658
temixys 1659
temovate external cream 1660
temozolomide 1661
tenofovir disoproxil fumarate 1662
testosterone transdermal gel 10 mg/act (2%) 1663
testosterone transdermal gel 12.5 mg/act (1%), 50 mg/5gm (1%) 1665
testosterone transdermal gel 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%) 1667
testosterone transdermal gel 25 mg/2.5gm (1%) 1669
testosterone transdermal solution 1671
tetrabenazine oral tablet 12.5 mg 1673
tetrabenazine oral tablet 25 mg 1674
tgt nicotine step one 1675
tgt nicotine step three 1676
tgt nicotine step two 1677
thalomid 1678

thiola 1679
thiola ec 1680
thrive mouth/throat gum 2 mg 1681
tiagabine hcl oral tablet 12 mg, 4 mg 1682
tiagabine hcl oral tablet 16 mg 1683
tiagabine hcl oral tablet 2 mg 1684
tiazac oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg, 420 mg 1685
tiazac oral capsule extended release 24 hour 240 mg 1686
tibsovo 1687
tiglutik 1688
tivicay oral tablet 10 mg, 25 mg 1689
tivicay oral tablet 50 mg 1690
tobi 1691
tobi podhaler 1692
tobramycin inhalation 1693
tolterodine tartrate er 1694
topamax sprinkle 1695
topicort external ointment 0.25 % 1696
toviaz 1697
tracleer oral tablet soluble 1698
tramadol hcl er (biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg 1703
tramadol hcl er oral tablet extended release 24 hour 1701
tramadol hcl oral 1699
tramadol-acetaminophen 1705
tranexamic acid oral 1707
trelegy ellipta 1708
trelstar mixject 1709
tremfya subcutaneous solution pen-injector 1710
tremfya subcutaneous solution prefilled syringe 1711
treprostinil 1712
tretinoin external 1713
tretinoin microsphere 1715
tretinoin microsphere pump 1717
tretten 1719
trezix oral capsule 320.5-30-16 mg 1720
triamcinolone acetonide external cream 0.1 % 1722
triamcinolone acetonide external ointment 0.1 % 1723
triamcinolone acetonide nasal aerosol 1724
tribenzor 1725
tricor 1726
triderm external cream 0.1 % 1727
trientine hcl 1728
trilipix 1729
trintellix 1730
triptodur 1732
triumeq 1733
trivisc 1734
trizivir 1735
trokendi xr oral capsule extended release 24 hour 100 mg, 25 mg, 50 mg 1736
trokendi xr oral capsule extended release 24 hour 200 mg 1737
trospium chloride 1738
trospium chloride er 1739
trulance 1740
trulicity 1741
truvada 1742
tudorza pressair inhalation aerosol powder breath activated 400 mcg/act 1743
tussicaps oral capsule extended release 12 hour 10-8 mg 1744
tuxarin er 1745
twynsta 1746
tybost 1747
tykerb 1748
tylenol with codeine #3 1749
tylenol with codeine #4 1751
tymlos 1753
tysabri 1754
tyvaso 1755
tyvaso refill 1756
tyvaso starter 1757
uceris oral 1758
uceris rectal 1759

udenyca 1760
ulesfia 1761
ultracet 1762
ultram 1764
ultravate external lotion 1766
uptravi oral tablet 1000 mcg, 1200 mcg, 1400 mcg, 1600 mcg, 400 mcg, 600 mcg, 800 mcg 1767
uptravi oral tablet 200 mcg 1768
uptravi oral tablet therapy pack 1768
utibron neohaler 1769
valchlor 1770
valcyte oral solution reconstituted 1771
valcyte oral tablet 1772
valganciclovir hcl oral solution reconstituted 1773
valganciclovir hcl oral tablet 1774
valsartan 1775
valsartan-hydrochlorothiazide 1776
valtrex 1777
varubi oral 1778
vascepa oral capsule 0.5 gm 1779
vascepa oral capsule 1 gm 1780
vecamyl 1781
veletri 1782
veltassa 1783
veltin 1785
vemlidy 1786
venclexta oral tablet 10 mg 1787
venclexta oral tablet 100 mg 1788
venclexta oral tablet 50 mg 1789
venclexta starting pack 1790
venlafaxine hcl er oral capsule extended release 24 hour 150 mg 1795
venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg 1796
venlafaxine hcl er oral tablet extended release 24 hour 225 mg 1797
venlafaxine hcl oral tablet 100 mg, 25 mg 1791
venlafaxine hcl oral tablet 37.5 mg 1792
venlafaxine hcl oral tablet 50 mg 1793
venlafaxine hcl oral tablet 75 mg 1794
ventavis 1798
verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg 1799
verapamil hcl er oral capsule extended release 24 hour 200 mg 1800
versacloz 1801
verzenio 1802
viberzi 1803
vicodin es oral tablet 7.5-300 mg 1804
vicodin hp oral tablet 10-300 mg 1806
victoza subcutaneous solution pen-injector 1808
videx ec oral capsule delayed release 125 mg, 200 mg, 250 mg 1810
videx oral solution reconstituted 2 gm 1809
viekira pak 1811
vigabatrin oral packet 1812
vigabatrin oral tablet 1813
vigadrone 1814
viibryd oral tablet 1815
vimizim 1816
vimpat oral solution 1817
vimpat oral tablet 1818
viokace 1819
viracept oral tablet 250 mg 1820
viracept oral tablet 625 mg 1821
viramune oral suspension 1822
viramune oral tablet 1823
viramune xr oral tablet extended release 24 hour 400 mg 1824
viread oral powder 1825
viread oral tablet 1826
visco-3 intra-articular solution prefilled syringe 1827
vistogard 1828
visudyne 1829
vitrakvi oral capsule 100 mg 1830
vitrakvi oral capsule 25 mg 1831
vitrakvi oral solution 1832
vizimpro 1833
vonvendi 1834

vosevi 1835
votrient 1836
vpriv 1837
vraylar oral capsule 1.5 mg 1838
vraylar oral capsule 3 mg 1840
vraylar oral capsule 4.5 mg, 6 mg 1842
vraylar oral capsule therapy pack 1844
vytorin 1845
vyvanse oral capsule 1846
vyvanse oral tablet chewable 1847
vyzulta 1848
wellbutrin sr 1849
wide-seal diaphragm 60 1850
wide-seal diaphragm 65 1851
wide-seal diaphragm 70 1852
wide-seal diaphragm 75 1853
wide-seal diaphragm 80 1854
wide-seal diaphragm 85 1855
wide-seal diaphragm 90 1856
wide-seal diaphragm 95 1857
wixela inhub 1858
xalatan 1859
xalkori 1860
xarelto oral tablet 10 mg, 20 mg 1861
xarelto oral tablet 15 mg 1862
xarelto oral tablet 2.5 mg 1863
xarelto starter pack 1864
xatmep 1865
xeljanz 1866
xeljanz xr 1867
xelpros 1868
xenazine oral tablet 12.5 mg 1869
xenazine oral tablet 25 mg 1870
xeomin 1871
xepi 1872
xermelo 1873
xgeva 1874
xifaxan oral tablet 200 mg 1875
xifaxan oral tablet 550 mg 1876
xigduo xr oral tablet extended release 24 hour 2.5-1000 mg 1877
xigduo xr oral tablet extended release 24 hour 5-1000 mg 1878
xodol oral tablet 5-300 mg 1879
xofluza 1881
xolair 1882
xopenex hfa 1883
xospata 1884
xpovio (100 mg once weekly) 1885
xpovio (60 mg once weekly) 1886
xpovio (80 mg once weekly) 1887
xpovio (80 mg twice weekly) 1888
xtampza er 1889
xtandi 1891
xultophy 1892
xuriden 1893
xyntha intravenous kit 1000 unit, 2000 unit, 250 unit, 500 unit 1894
xyntha solofuse intravenous kit 3000 unit 1895
xyosted 1896
xyrem 1898
yervoy 1899
yonsa 1900
yupelri 1901
zafirlukast 1902
zaleplon 1903
zaltrap 1904
zarxio 1905
zavesca 1906
zegerid otc 1907
zejula 1908
zelboraf 1909
zemaira 1910
zembrace symtouch 1911
zemplar oral capsule 1 mcg 1912
zemplar oral capsule 2 mcg 1913
zenatane oral capsule 10 mg, 20 mg, 40 mg 1914
zenatane oral capsule 30 mg 1914
zenzedi oral tablet 10 mg, 5 mg 1915
zepatier 1916
zerit oral capsule 30 mg 1917

zerit oral capsule 40 mg 1918
zetia 1919
zetonna 1920
ziagen oral solution 1921
ziagen oral tablet 1922
ziana 1923
zidovudine oral capsule 1924
zidovudine oral syrup 1925
zidovudine oral tablet 1926
zileuton er 1927
zioptan 1928
ziprasidone hcl 1929
zocor 1930
zohydro er oral capsule er 12 hour abuse-deterrent 1931
zolinza 1933
zolmitriptan oral 1934
zoloft oral tablet 100 mg 1935
zoloft oral tablet 25 mg 1936
zoloft oral tablet 50 mg 1937
zolpidem tartrate er 1939
zolpidem tartrate oral 1938
zomacton 1940
zomig nasal solution 2.5 mg 1941
zomig nasal solution 5 mg 1942
zomig oral 1943
zomig zmt 1944
zonalon 1945
zontivity 1946
zorbtive 1947
zubsolv sublingual tablet sublingual 0.7-0.18 mg 1948
zubsolv sublingual tablet sublingual 1.4-0.36 mg, 11.4-2.9 mg, 2.9-0.71 mg, 5.7-1.4 mg, 8.6-2.1 mg 1949
zydelig 1950
zyflo 1951
zykadia oral tablet 1952
zyprexa oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg 1953
zyprexa oral tablet 2.5 mg 1955
zyprexa zydis 1957
zytiga oral tablet 250 mg 1959
zytiga oral tablet 500 mg 1960
zyvox oral tablet 1961