### 2019 Aetna Small Group ACA: FL 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

# **Acamprosate Calcium**

### **Products Affected**

• acamprosate calcium

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

### **Accu-Chek Aviva Plus**

### **Products Affected**

### ACCU-CHEK AVIVA PLUS IN VITRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Accu-Chek Compact Plus**

### **Products Affected**

ACCU-CHEK COMPACT PLUS

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Accu-Chek SmartView**

### **Products Affected**

### ACCU-CHEK SMARTVIEW

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Accu-Chek Softclix Lancet Dev**

### **Products Affected**

 ACCU-CHEK SOFTCLIX LANCET DEV KIT

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

## **Accutrend Glucose**

### **Products Affected**

### ACCUTREND GLUCOSE

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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

2019 Aetna Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	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 oral capsule 10 mg, 25 mg

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

## Acitretin

### **Products Affected**

• acitretin oral capsule 17.5 mg

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

### Actemra

### **Products Affected**

### ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Act emra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Act emra.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

### **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/Act emra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Act emra.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

### 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/acti mmune.html
Exclusion Criteria	
Required Medical Information	
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

# **Actoplus met XR**

### **Products Affected**

ACTOPLUS MET XR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of metformin 1500mg/day
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Aczone

### **Products Affected**

• ACZONE EXTERNAL GEL 7.5 %

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

# Adagen

### **Products Affected**

ADAGEN

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

# Adapalene

### **Products Affected**

- adapalene external gel 0.3 %
- adapalene external lotion

ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Adapalene

Products Affected
• adapatene 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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/pulmon aryhypertensionagents.html
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

# Addyi

### **Products Affected**

### ADDYI

PA Criteria	Criteria Details
Covered Uses	Treatment of premenopausal women with acquired, generalized hypoactive sexual desire disorder (HSDD) as characterized by low sexual desire that causes marked distress or interpersonal difficulty and is not due to a co-existing medical or psychiatric condition, problems within the relationship, or the effects of a medication or other drug substance
Exclusion Criteria	
Required Medical Information	The patient is a premenopausal female 18 years of age or older with a documented diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) that is appropriately documented (i.e., evaluated by a complete clinical assessment, using DSM-4, interviews/questionnaires), and hypoactive sexual desire disorder (HSDD) is not caused by a co-existing medical or psychiatric condition, problems within the relationship, or the effects of a medication or other drug substance, and the patient does not have any of the following: alcohol use, concomitant use of Addyi with moderate or strong CYP3A4 inhibitors, or hepatic impairment. For renewals only: The patient is a premenopausal female 18 years of age or older with a documented diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) that is appropriately documented (i.e., evaluated by a complete clinical assessment, using DSM-4, interviews/questionnaires), and the patient has been receiving the requested drug for at least 8 weeks and has reported symptom improvement.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 weeks - Renewal: 1 year

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: March 20, 2018 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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/pulmon aryhypertensionagents.html
QL Criteria	3 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

### **Advair Diskus**

#### **Products Affected**

 ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 250-50 MCG/DOSE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Dulera or generic fluticasone/salmeterol (step therapy does not apply for COPD diagnosis, only asthma diagnosis)
QL Criteria	1 diskus Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

### **Advair Diskus**

#### **Products Affected**

 ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 500-50 MCG/DOSE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Dulera or generic fluticasone/salmeterol (step therapy does not apply for COPD diagnosis, only asthma diagnosis)
QL Criteria	2 inhalers Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

### **Advair HFA**

#### **Products Affected**

#### ADVAIR HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Dulera or generic fluticasone/salmeterol (step therapy does not apply for COPD diagnosis, only asthma diagnosis)
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

### **Advance Intuition Test**

#### **Products Affected**

#### ADVANCE INTUITION TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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 Redi-Code**

#### **Products Affected**

### • ADVOCATE REDI-CODE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Advocate Redi-Code+ Test**

#### **Products Affected**

ADVOCATE REDI-CODE+ TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Advocate Test**

#### **Products Affected**

### ADVOCATE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aemcolo

# Products AffectedAEMCOLO

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

### Afeditab CR

#### **Products Affected**

 afeditab cr oral tablet extended release 24 hour 60 mg

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

### **Afinitor**

#### **Products Affected**

#### AFINITOR

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

# **Afinitor Disperz**

#### **Products Affected**

 AFINITOR DISPERZ ORAL TABLET SOLUBLE 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

# **AgaMatrix AMP Test**

#### **Products Affected**

#### AGAMATRIX AMP TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **AgaMatrix Jazz Test**

#### **Products Affected**

AGAMATRIX JAZZ TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **AgaMatrix KeyNote Test**

#### **Products Affected**

AGAMATRIX KEYNOTE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **AgaMatrix Presto Test**

#### **Products Affected**

### AGAMATRIX PRESTO TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aimovig

#### **Products Affected**

 AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML

PA Criteria	Criteria Details
Covered Uses	Clinical 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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Fill- 3 months
Other Criteria	Continuation criteria- 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 pen Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 14, 2019 Quantity Limits: August 25, 2015

# Aimovig

#### **Products Affected**

 AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML

PA Criteria	Criteria Details
Covered Uses	Clinical 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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Fill- 3 months
Other Criteria	Continuation criteria- 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	2 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 14, 2019 Quantity Limits: August 25, 2015

# Aimovig (140 MG Dose)

#### **Products Affected**

• AIMOVIG (140 MG DOSE)

PA Criteria	Criteria Details
Covered Uses	Clinical 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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Fill- 3 months
Other Criteria	Continuation criteria- 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	2 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 14, 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

# 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 aprepitant and either ondansetron or granisetron
QL Criteria	2 capsules Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

#### **Products Affected**

• alendronate sodium oral tablet 10 mg

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

#### **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

#### **Products Affected**

• alendronate sodium oral tablet 40 mg, 5 mg

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

#### **Products Affected**

• alendronate sodium oral tablet 70 mg

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

### **Alfuzosin HCl ER**

**Products Affected**• alfuzosin hcl er

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

### Alinia

#### **Products Affected**

 ALINIA ORAL SUSPENSION RECONSTITUTED

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

### Alinia

#### **Products Affected**

ALINIA ORAL TABLET

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

### **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

# **Almotriptan Malate**

#### **Products Affected**

• almotriptan malate

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 tablets Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Alogliptin Benzoate**

#### **Products Affected**

• alogliptin benzoate

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

# **Alogliptin-Metformin HCl**

#### **Products Affected**

• alogliptin-metformin hcl

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

## Alogliptin-Pioglitazone

### **Products Affected**

alogliptin-pioglitazone

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

## **Alosetron HCl**

### **Products Affected**

• alosetron hcl

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of diphenoxylate/atropine and loperamide
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## ALPRAZolam XR

**Products Affected**• alprazolam xr

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

## Altoprev

### **Products Affected**

### ALTOPREV

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastatin
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Alvesco

### **Products Affected**

ALVESCO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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/pulmon aryhypertensionagents.html
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

## Amabelz

### **Products Affected**

AMABELZ

QL Criteria	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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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

## Amcinonide

#### **Products Affected**

• amcinonide external cream

• amcinonide external lotion

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Amitiza**

### **Products Affected**

AMITIZA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of lactulose or polyethylene glycol
QL Criteria	2 caps Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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
<b>Covered Uses</b>	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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Amphetamine Sulfate**

### **Products Affected**

• amphetamine sulfate

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

## **Amphetamine-Dextroamphet ER**

### **Products Affected**

• amphetamine-dextroamphet er

PA Criteria	Criteria Details
<b>Covered Uses</b>	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 an immediate release stimulant
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 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 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Anoro Ellipta**

### **Products Affected**

ANORO ELLIPTA

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

### **Anzemet**

### **Products Affected**

ANZEMET ORAL

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

## **APAP-Caff-Dihydrocodeine**

### **Products Affected**

• apap-caff-dihydrocodeine oral capsule

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological 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 Small Group ACA: FL

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	10 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Apidra

### **Products Affected**

APIDRA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Apidra SoloStar

### **Products Affected**

 APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Aprepitant**

### **Products Affected**

• aprepitant oral capsule 125 mg, 40 mg, 80 mg

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

## **Aprepitant**

### **Products Affected**

• aprepitant oral capsule 80 & 125 mg

QL Criteria	9 capsules Per 30 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 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Products Affected**

APTIOM ORAL TABLET 200 MG

QL Criteria	6 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

### **Products Affected**

APTIOM ORAL TABLET 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

### **Products Affected**

APTIOM ORAL TABLET 600 MG

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

### **Products Affected**

APTIOM ORAL TABLET 800 MG

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

## **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

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

## 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/Arca lyst.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Arcapta Neohaler

### **Products Affected**

### ARCAPTA NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Serevent
QL Criteria	1 cap Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 05, 2018 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

# 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

# **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

2019 Aetna Small Group ACA: FL

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	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)

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Asmanex (14 Metered Doses)**

### **Products Affected**

ASMANEX (14 METERED DOSES)

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Asmanex (30 Metered Doses)

### **Products Affected**

• ASMANEX (30 METERED DOSES)

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Asmanex (60 Metered Doses)

### **Products Affected**

• ASMANEX (60 METERED DOSES)

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Asmanex (7 Metered Doses)**

### **Products Affected**

• ASMANEX (7 METERED DOSES)

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Asmanex HFA**

### **Products Affected**

### ASMANEX HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Assure 3 Test**

### **Products Affected**

### ASSURE 3 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Assure 4 Test**

### **Products Affected**

### ASSURE 4 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Assure Platinum**

### **Products Affected**

### • ASSURE PLATINUM

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Assure Pro Test**

### **Products Affected**

ASSURE PRO TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Atazanavir Sulfate**

### **Products Affected**

atazanavir sulfate oral capsule 150 mg, 300 mg

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

# **Atazanavir Sulfate**

### **Products Affected**

• atazanavir sulfate oral capsule 200 mg

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

# **Atomoxetine HCl**

### **Products Affected**

• atomoxetine hcl oral capsule 10 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: October 18, 2017

# **Atomoxetine HCl**

### **Products Affected**

• atomoxetine hcl oral capsule 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: October 18, 2017

### **Atorvastatin Calcium**

### **Products Affected**

 atorvastatin calcium oral tablet 10 mg, 40 mg, 80 mg

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

# **Atorvastatin Calcium**

### **Products Affected**

• atorvastatin calcium 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

# 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/Auba gio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Auba gio.html
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

### Avandia

### **Products Affected**

 AVANDIA ORAL TABLET 2 MG, 4 MG

QL Criteria	1 tab 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

### Avita

### **Products Affected**

avita external cream

### AVITA EXTERNAL GEL

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

<b>Revision Date</b>	Prior Authorization: March 13, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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### Avonex

### **Products Affected**

### • AVONEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSIn terferons.html
QL Criteria	1 kit Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSIn terferons.html
QL Criteria	4 pens Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSIn terferons.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

# **Balsalazide Disodium**

### **Products Affected**

• balsalazide disodium

QL Criteria	9 caps 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 tabs 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

# **Bayer Breeze 2 Test**

#### **Products Affected**

BAYER BREEZE 2 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Bayer Contour Next Test**

#### **Products Affected**

#### • BAYER CONTOUR NEXT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Bayer Contour Test**

#### **Products Affected**

### • BAYER CONTOUR TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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 fluticasone propionate and flunisolide
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Belsomra

#### **Products Affected**

 BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Insomnia
Exclusion Criteria	
Required Medical Information	A diagnosis of insomnia
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 either zolpidem tartrate or zalelpon, and through zolpidem tartrate extended-release
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Belviq**

# Products AffectedBELVIQ

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30kg/m2 or BMI greater than 27kg/m2 with one or more of the items in the required medical information section
Exclusion Criteria	Concomitant use of two or more anti-obesity agents, pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140mm Hg or diastolic blood pressure greater than 90mm Hg on more than one occasion), Dyslipidemia (LDL cholesterol greater than/= 160mg/dL: HDL cholesterol less than 35mg/dL: triglycerides greater than/= 400mg/dL), Type 2 Diabetes Mellitus, Coronary Heart Disease, or Obstructive Sleep Apnea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: The member has lost at least 5% of body weight from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of phentermine cap or phendimetrazine tab
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

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The formulary is updated the first week of each month. 12/01/2019

# 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/benl ysta.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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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	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

## **Betamethasone Dipropionate Aug**

#### **Products Affected**

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

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

# **Betamethasone Dipropionate Aug**

### **Products Affected**

• betamethasone dipropionate aug external lotion

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

### **Betamethasone Valerate**

#### **Products Affected**

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Betaseron

#### **Products Affected**

#### • BETASERON SUBCUTANEOUS KIT

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

### 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/T argretin.html
Exclusion Criteria	
Required Medical 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 tab 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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 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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Antineoplastics.html
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: August 25, 2015

### **Bosulif**

#### **Products Affected**

• BOSULIF ORAL TABLET 400 MG

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

### **Bosulif**

#### **Products Affected**

BOSULIF ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: August 25, 2015

# **Breo Ellipta**

#### **Products Affected**

### • BREO ELLIPTA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Dulera or generic fluticasone/salmeterol (step therapy does not apply for COPD diagnosis, only asthma diagnosis)
QL Criteria	2 blisters Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 08, 2019 Quantity Limits: August 25, 2015

## **Brilinta**

#### **Products Affected**

• BRILINTA ORAL TABLET 60 MG

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

## **Brilinta**

#### **Products Affected**

• BRILINTA ORAL TABLET 90 MG

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

### Brovana

#### **Products Affected**

### • BROVANA

PA Criteria	Criteria Details
<b>Covered Uses</b>	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	60 vials Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 05, 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	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 2.1-0.3 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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: June 05, 2018 Quantity Limits: August 25, 2015

### Bunavail

#### **Products Affected**

 BUNAVAIL BUCCAL FILM 4.2-0.7 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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: June 05, 2018 Quantity Limits: August 25, 2015

### Bunavail

#### **Products Affected**

#### • BUNAVAIL BUCCAL FILM 6.3-1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	2 films Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Buprenorphine

#### **Products Affected**

• buprenorphine transdermal

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

The formulary is updated the first week of each month. 12/01/2019

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 12-3 mg, 2-0.5 mg, 4-1 mg

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 film 8-2 mg

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

## **buPROPion HCl**

#### **Products Affected**

• bupropion hel oral

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

## **BuPROPion HCl ER (Smoking Det)**

### **Products Affected**

• bupropion hcl er (smoking det)

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

## buPROPion HCl ER (XL)

### **Products Affected**

• bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg

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

# **BuPROPion HCl ER (XL)**

### **Products Affected**

• bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg

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

### **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

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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	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

2019 Aetna Small Group ACA: FL

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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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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

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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	2 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Bydureon**

### **Products Affected**

 BYDUREON SUBCUTANEOUS PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Bydureon**

### **Products Affected**

 BYDUREON SUBCUTANEOUS SUSPENSION RECONSTITUTED ER

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Bydureon BCise**

### **Products Affected**

### BYDUREON BCISE

PA Criteria	Criteria Details
<b>Covered Uses</b>	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 two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Byetta 10 MCG Pen

### **Products Affected**

 BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	1 pen Per 1 fill
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Byetta 5 MCG Pen

#### **Products Affected**

 BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	1 pen Per 1 fill
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Bystolic**

### **Products Affected**

 BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 5 MG

QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Bystolic**

### **Products Affected**

• BYSTOLIC ORAL TABLET 20 MG

QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 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/cabli vi.html
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

# Calcipotriene

### **Products Affected**

calcipotriene external

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: June 05, 2018 Quantity Limits: August 25, 2015

## **Calcipotriene-Betameth Diprop**

### **Products Affected**

• calcipotriene-betameth diprop

ST Criteria	A documented contraindication, intolerance, allergy, or failure of calcipotriene and a medium to high potency topical steroid
QL Criteria	60 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Calcitonin (Salmon)**

### **Products Affected**

• calcitonin (salmon)

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	1 bottle Per 1 fill
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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: June 05, 2018 Quantity Limits: August 25, 2015

### Canasa

### **Products Affected**

CANASA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Apriso
QL Criteria	1 suppository Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Candesartan Cilexetil**

### **Products Affected**

candesartan cilexetil

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

### **Candesartan Cilexetil-HCTZ**

### **Products Affected**

• candesartan cilexetil-hctz

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

## Capecitabine

### **Products Affected**

capecitabine

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

## Capex

### **Products Affected**

CAPEX

QL Criteria	120 ml Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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 tabs 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 tab 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/meta bolic_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

## Cardura XL

### **Products Affected**

• CARDURA XL

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

### CareSens N Glucose Test

### **Products Affected**

### • CARESENS N GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Cartia XT

### **Products Affected**

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

QL Criteria	1 cap 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 caps 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of carvedilol
QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Celecoxib**

### **Products Affected**

celecoxib oral

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two non steroidal anti-inflammatory drugs (NSAID)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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/gau cher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Cesamet

### **Products Affected**

CESAMET

QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: April 08, 2019

## **Cevimeline HCl**

### **Products Affected**

cevimeline hcl

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

## **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 AffectedCHENODAL

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	

<b>Revision Date</b>	Prior Authorization: February 02, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# **Chorionic Gonadotropin**

### **Products Affected**

• chorionic gonadotropin intramuscular

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/infer tility.html
Exclusion Criteria	
Required Medical Information	
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
<b>Covered Uses</b>	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (paraaminosalicylic 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
<b>Covered Uses</b>	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (paraaminosalicylic 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: August 25, 2015

## Cimzia

### **Products Affected**

 CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

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

## Citalopram Hydrobromide

### **Products Affected**

• citalopram hydrobromide oral tablet 40 mg

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

## Claravis

### **Products Affected**

claravis

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Clever Chek Auto-Code Test**

### **Products Affected**

### • CLEVER CHEK AUTO-CODE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Clever Chek Auto-Code Voice**

### **Products Affected**

• CLEVER CHEK AUTO-CODE VOICE IN VITRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Clever Chek Test**

### **Products Affected**

### • CLEVER CHEK TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Clever Choice Auto-Code Test**

### **Products Affected**

• CLEVER CHOICE AUTO-CODE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Clever Choice Micro Test**

### **Products Affected**

### • CLEVER CHOICE MICRO TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Climara Pro

### **Products Affected**

· CLIMARA PRO

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

## 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

#### **Products Affected**

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Products Affected**

• clobetasol propionate external foam

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

### **Products Affected**

• clobetasol propionate external liquid

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

### **Products Affected**

• clobetasol propionate external lotion

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	236 ml Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Products Affected**

• clobetasol propionate external shampoo

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

### **Products Affected**

• clobetasol propionate external solution

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	100 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Products Affected**

• clobetasol propionate e

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Clobetasol Propionate Emulsion**

### **Products Affected**

• clobetasol propionate emulsion

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

## 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

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

# **Clopidogrel Bisulfate**

### **Products Affected**

• clopidogrel bisulfate oral tablet 300 mg

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

# **Clopidogrel Bisulfate**

### **Products Affected**

• clopidogrel bisulfate oral tablet 75 mg

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

#### **Products Affected**

• clozapine oral tablet 100 mg

• clozapine oral tablet dispersible 100 mg

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

#### **Products Affected**

• clozapine oral tablet 200 mg

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

#### **Products Affected**

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

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

#### **Products Affected**

• clozapine oral tablet dispersible 12.5 mg

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

#### **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

#### **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

## **Codeine Sulfate**

#### **Products Affected**

• codeine sulfate oral tablet 15 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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	24 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 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

2019 Aetna Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Colchicine**

#### **Products Affected**

• colchicine 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: July 03, 2019

## CombiPatch

#### **Products Affected**

COMBIPATCH

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

# **Combivent Respimat**

#### **Products Affected**

COMBIVENT RESPIMAT

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

## Cometriq (100 mg Daily Dose)

#### **Products Affected**

• COMETRIQ (100 MG DAILY DOSE)

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

## 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 capsules 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 capsules 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 tab Per 1 Day
Notes/ References	
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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/glatir amer.html
Exclusion Criteria	
Required Medical Information	
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

## Cordran

#### **Products Affected**

CORDRAN EXTERNAL TAPE

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

## 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 of the preferred ACEI or ARB
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month.

12/01/2019

# **Cormax Scalp Application**

#### **Products Affected**

• cormax scalp application

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	100 ml Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Cortifoam

#### **Products Affected**

CORTIFOAM

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

### **Creon**

#### **Products Affected**

### CREON

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Crinone

#### **Products Affected**

• CRINONE VAGINAL GEL 4 %

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Not covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Covered for prevention of early pregnancy failure, for ART (Assisted Reproductive Technology) when there is a documented diagnosis of progesterone deficiency in an infertile woman who has infertility coverage, and for secondary amenorrhea when there is a documented diagnosis of progesterone deficiency in an infertile woman who has infertility coverage
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Crinone**

#### **Products Affected**

• CRINONE VAGINAL GEL 8 %

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Not covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Covered for prevention of early pregnancy failure, for ART (Assisted Reproductive Technology) when there is a documented diagnosis of progesterone deficiency in an infertile woman who has infertility coverage, and for secondary amenorrhea when there is a documented diagnosis of progesterone deficiency in an infertile woman who has infertility coverage
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Crinone 4%
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 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

## Cuvposa

#### **Products Affected**

### CUVPOSA

PA Criteria	Criteria Details
Covered Uses	neurologic conditions associated with drooling (e.g. cerebral palsy)
Exclusion Criteria	
Required Medical Information	Documentation of neurologic conditions associated with drooling (e.g. cerebral palsy) to reduce severe chronic drooling
Age Restrictions	3 years to 16 years
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

# Cycloset

#### **Products Affected**

CYCLOSET

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

## Cystadane

### **Products Affected**

#### CYSTADANE

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

## 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/lys osomal_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/ophth almic_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

## **Daklinza**

#### **Products Affected**

#### DAKLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Daklinz a.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Daklinz a.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

# **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
<b>Covered Uses</b>	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 Incruse and generic fluticasone/salmeterol.
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
<b>Covered Uses</b>	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 Incruse and generic fluticasone/salmeterol.
QL Criteria	1 tab 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 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Darifenacin Hydrobromide ER

### **Products Affected**

• darifenacin hydrobromide er

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR and through either Vesicare or Myrbetriq
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **D**aytrana

### **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 an immediate release stimulant
QL Criteria	1 patch Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 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/Anti dotes.html
Exclusion Criteria	
Required Medical Information	
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/antivira l_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 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

# Denavir

### **Products Affected**

• DENAVIR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oral acyclovir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 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/meta bolic_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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Desloratadine**

### **Products Affected**

• desloratadine oral tablet dispersible 5 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Claritin OTC, Zyrtec OTC, or Allegra OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Desonide**

### **Products Affected**

desonide external

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alclometasone cream/ointment
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Desoximetasone**

#### **Products Affected**

- desoximetasone external cream
- desoximetasone external ointment

• desoximetasone external gel

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Desvenlafaxine Succinate ER**

### **Products Affected**

• desvenlafaxine succinate er

PA Criteria	Criteria Details
<b>Covered Uses</b>	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder. Continuation Criteria: Member continues to meet Required Medical Information and Other Criteria AND There is clinical documentation indicating disease stability or improvement from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) members dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) members dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Dexilant**

### **Products Affected**

### DEXILANT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/doc uments/2019 PPI Post Limit QL Criteria_Updateddoc
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 Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole (not required for Nexium Packet requests for members under one year of age)
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 02/2017

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

<b>Revision Date</b>	Prior Authorization: November 21, 2016 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015
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# **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, 25 mg, 30 mg, 35 mg, 40 mg, 5 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 an immediate release stimulant
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Dextroamphetamine Sulfate**

### **Products Affected**

• dextroamphetamine sulfate oral solution

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) OR Narcolepsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD OR Narcolepsy AND there is clinical documentation indicating disease stability or improvement from baseline
QL Criteria	40 ML Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Dextroamphetamine Sulfate**

### **Products Affected**

• dextroamphetamine sulfate oral tablet

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

# **Dextroamphetamine Sulfate ER**

### **Products Affected**

• dextroamphetamine sulfate er

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

# **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/MIS C/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/MIS C/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

# **DiazePAM**

Products Affected
• diazepam rectal

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

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

# **Dificid**

### **Products Affected**

### DIFICID

PA Criteria	Criteria Details
Covered Uses	clostridium difficile associated diarrhea
Exclusion Criteria	Initial episodes of mild, moderate, or severe CDI.Severe complicated CDI (i.e. hypotension, ileus, megacolon, or shock).
Required Medical Information	A diagnosis of clostridium difficile associated diarrhea in adults
Age Restrictions	18 years old or greater
Prescriber Restrictions	
Coverage Duration	10 Days of therapy
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two courses of antibiotics, metronidazole and/or oral vancomycin
QL Criteria	20 tabs Per 1 fill
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Diflorasone Diacetate**

Products Affected
• diflorasone diacetate external

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Dihydroergotamine Mesylate

### **Products Affected**

• dihydroergotamine mesylate nasal

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	8 vials Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **DilTIAZem CD**

### **Products Affected**

diltiazem cd oral capsule extended release
 24 hour 120 mg, 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 CD**

### **Products Affected**

diltiazem cd oral capsule extended release
 24 hour 240 mg

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

### **DilTIAZem CD**

### **Products Affected**

diltiazem cd oral capsule extended release
 24 hour 300 mg

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

### dilTIAZem HCl ER

### **Products Affected**

• diltiazem hel er oral capsule extended release 24 hour 240 mg

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

# **Diltiazem HCl ER Beads**

### **Products Affected**

• diltiazem hel er beads oral capsule extended release 24 hour 120 mg, 300 mg, 360 mg

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

## **Diltiazem HCl ER Beads**

## **Products Affected**

• diltiazem hel er beads oral capsule extended release 24 hour 240 mg

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

## **Diltiazem HCl ER Beads**

## **Products Affected**

• diltiazem hel 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: August 25, 2015

## **DilTIAZem HCl ER Beads**

## **Products Affected**

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

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

## **Diltiazem HCl ER Coated Beads**

## **Products Affected**

• diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg

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

## **Diltiazem HCl ER Coated Beads**

#### **Products Affected**

• diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 300 mg, 360 mg

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

## **Diltiazem HCl ER Coated Beads**

#### **Products Affected**

• diltiazem hel er coated beads oral tablet extended release 24 hour 240 mg

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

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

## **DilTIAZem HCl ER Coated Beads**

## **Products Affected**

• diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg

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

## Dilt-XR

## **Products Affected**

 dilt-xr 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

# **Dipentum**

## **Products Affected**

• DIPENTUM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Apriso and balsalazide
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Divigel

#### **Products Affected**

 DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 1 MG/GM

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

# 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

# **Donepezil HCl**

## **Products Affected**

- donepezil hcl oral tablet 10 mg, 5 mg
- donepezil hcl oral tablet dispersible

PA Criteria	Criteria Details
<b>Covered Uses</b>	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

# **Donepezil HCl**

## **Products Affected**

donepezil hcl oral tablet 23 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of donepezil 10mg
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: June 05, 2018 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: August 25, 2015

## 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

# **Doxepin HCl**

## **Products Affected**

doxepin hcl external

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

## **Doxercalciferol**

## **Products Affected**

doxercalciferol oral

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

## **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/meta bolic_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	
ST Criteria	FOR CHEMOTHERAPY INDUCED NAUSEA AND VOMITING ONLY: A documented contraindication, intolerance, allergy, or failure of prochlorperazine, chlorpromazine, haloperidol or metoclopramide
QL Criteria	2 caps Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Duavee**

## **Products Affected**

## DUAVEE

PA Criteria	Criteria Details
Covered Uses	Treatment of moderate to severe vasomotor symptoms associated with menopause, Prevention of postmenopausal osteoporosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause or prevention of postmenopausal osteoporosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of estrogen products and raloxifene
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Dulera

## **Products Affected**

DULERA

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

## **DULoxetine HCl**

## **Products Affected**

 duloxetine hcl oral capsule delayed release particles 20 mg

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

## **DULoxetine HCl**

## **Products Affected**

• duloxetine hcl oral capsule delayed release particles 30 mg, 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

## **DULoxetine HCl**

## **Products Affected**

 duloxetine hcl oral capsule delayed release particles 60 mg

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

# **Dutasteride**

## **Products Affected**

• dutasteride oral

ST Criteria	A documented contraindication, intolerance, allergy, or failure of finasteride
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Easy Plus II Glucose Test**

## **Products Affected**

• EASY PLUS II GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Easy Step Test**

## **Products Affected**

## EASY STEP TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Easy Talk Blood Glucose Test**

## **Products Affected**

EASY TALK BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Easy Touch Test**

## **Products Affected**

• EASY TOUCH TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Easy Trak Blood Glucose Test**

## **Products Affected**

• EASY TRAK BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **EasyGluco**

## **Products Affected**

## · EASYGLUCO IN VITRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyMax 15 Test

## **Products Affected**

• EASYMAX 15 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **EASYMax Test**

## **Products Affected**

## EASYMAX TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **EasyPlus Blood Glucose Test**

## **Products Affected**

• EASYPLUS BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **EasyPRO Plus**

## **Products Affected**

## EASYPRO PLUS IN VITRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 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 preferred generic alternatives from the following agents: irbesartan, losartan, or telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 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 preferred alternatives from the following: irbesartan/hctz, losartan/hctz, or telmisartan/hctz
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Edurant

### **Products Affected**

• EDURANT

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

### **Element Test**

### **Products Affected**

### ELEMENT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 tablets Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Eligard

### **Products Affected**

• ELIGARD

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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 AffectedELIQUIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Xarelto and Pradaxa
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Eliquis Starter Pack**

### **Products Affected**

• ELIQUIS STARTER PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Xarelto and Pradaxa
QL Criteria	1 pack Per 365 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Elmiron**

### **Products Affected**

ELMIRON

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

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

### **Embrace Blood Glucose Test**

### **Products Affected**

EMBRACE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD), Parkinsons Disease
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder or Parkinsons Disease
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 patch 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

### **Emtriva**

### **Products Affected**

• EMTRIVA ORAL CAPSULE

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

### **Emverm**

### **Products Affected**

• EMVERM

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

### **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/En brel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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 28 Days
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	4 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA: FL The formulary is updated the first week of each month.

12/01/2019

## **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	4 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

## **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

2019 Aetna Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Endometrin

### **Products Affected**

### ENDOMETRIN

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), prevention of early pregnancy failure
Exclusion Criteria	Not covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Covered for prevention of early pregnancy failure and for ART (Assisted Reproductive Technology) when there is a documented diagnosis of progesterone deficiency in an infertile woman who has infertility coverage
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Enoxaparin Sodium**

### **Products Affected**

• enoxaparin sodium

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

### 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

# **Epaned**

### **Products Affected**

EPANED ORAL SOLUTION

QL Criteria	5 ml Per 1 Day
Notes/ References	Annual Review: 08/2017
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 09, 2018

## **Epclusa**

### **Products Affected**

• EPCLUSA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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/epidi olex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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

# **Epiduo Forte**

### **Products Affected**

### • EPIDUO FORTE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **EPINEPHrine**

### **Products Affected**

• epinephrine injection solution auto-injector 0.15 mg/0.15ml

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

### **EPINEPHrine**

### **Products Affected**

• epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml

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

## **Epogen**

#### **Products Affected**

 EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML

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

# **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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Erivedge

### **Products Affected**

ERIVEDGE

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

## **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

### Ertaczo

### **Products Affected**

ERTACZO

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

### **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/Idio pathic_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 09, 2018

### **Esbriet**

### **Products Affected**

• ESBRIET ORAL TABLET 267 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Idio pathic_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 09, 2018

### **Esbriet**

### **Products Affected**

• ESBRIET ORAL TABLET 801 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Idio pathic_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 09, 2018

# **Escitalopram Oxalate**

### **Products Affected**

• escitalopram oxalate oral tablet 10 mg

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

# **Escitalopram Oxalate**

### **Products Affected**

• escitalopram oxalate oral tablet 20 mg, 5 mg

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

# **Esomeprazole Magnesium**

### **Products Affected**

• esomeprazole magnesium oral capsule delayed release 40 mg

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/assets/doc uments/2019 PPI Post Limit QL Criteria_Updateddoc
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 Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole (not required for Nexium Packet requests for members under one year of age)
QL Criteria	1 capsule Per 1 Day
Notes/ References	

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015
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## **Estradiol**

### **Products Affected**

estradiol transdermal patch twice weekly

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

## **Estradiol**

### **Products Affected**

estradiol transdermal patch weekly

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

## **Estradiol-Norethindrone Acet**

### **Products Affected**

• estradiol-norethindrone acet oral tablet 0.5-0.1 mg

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

## **Estradiol-Norethindrone Acet**

#### **Products Affected**

 estradiol-norethindrone acet oral tablet 1-0.5 mg

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

# **Estrogel**

### **Products Affected**

ESTROGEL

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

# **Eszopiclone**

### **Products Affected**

eszopiclone

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

## **Evamist**

### **Products Affected**

• EVAMIST

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

## **EvenCare + Blood Glucose Test**

### **Products Affected**

• EVENCARE + BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **EvenCare Blood Glucose Test**

### **Products Affected**

EVENCARE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **EvenCare G2 Test**

### **Products Affected**

• EVENCARE G2 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **EvenCare G3 Test**

### **Products Affected**

• EVENCARE G3 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Evolution Autocode**

### **Products Affected**

### EVOLUTION AUTOCODE IN VITRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Evzio**

### **Products Affected**

• EVZIO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Narcan
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Exelderm**

### **Products Affected**

• EXELDERM 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 09, 2018

## **Exelderm**

### **Products Affected**

EXELDERM EXTERNAL SOLUTION

QL Criteria	60 ml Per 30 Days
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/Anti dotes.html
Exclusion Criteria	
Required Medical Information	
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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSIn terferons.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/ophth almic_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

# **Ez Smart Blood Glucose Test**

### **Products Affected**

• EZ SMART BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Ez Smart Plus Glucose Test**

### **Products Affected**

• EZ SMART PLUS GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastatin
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Famciclovir**

**Products Affected**• famciclovir oral

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

# **Fanapt**

### **Products Affected**

FANAPT

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

# **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: August 25, 2015

# **Felodipine ER**

### **Products Affected**

• felodipine er

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

# **Femring**

### **Products Affected**

FEMRING

QL Criteria	1 ring Per 90 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fenofibrate

### **Products Affected**

• fenofibrate oral capsule 150 mg, 50 mg

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

# **Fenofibrate**

### **Products Affected**

• fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg

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

# **Fenofibrate Micronized**

### **Products Affected**

• fenofibrate micronized

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

# **Fenofibric Acid**

**Products Affected**fenofibric acid oral tablet

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

### **FentaNYL**

### **Products Affected**

fentanyl

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

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The formulary is updated the first week of each month. 12/01/2019

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: 09/2017
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, 400 mcg, 600 mcg, 800 mcg

PA Criteria	Criteria Details
<b>Covered Uses</b>	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
<b>Covered Uses</b>	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 two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	120 lozenges Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: February 02, 2018 Step Therapy: June 05, 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/Anti dotes.html
Exclusion Criteria	
Required Medical Information	
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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 cap Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Fetzima Titration**

### **Products Affected**

### FETZIMA TITRATION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Fiasp

### **Products Affected**

• FIASP

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Fiasp FlexTouch

### **Products Affected**

• FIASP FLEXTOUCH

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Fiasp PenFill

### **Products Affected**

FIASP PENFILL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Fifty50 Glucose Test 2.0

### **Products Affected**

• FIFTY50 GLUCOSE TEST 2.0

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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/fird apse.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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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

# **Flovent Diskus**

### **Products Affected**

### FLOVENT DISKUS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	2 blisters Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Flovent HFA**

### **Products Affected**

### FLOVENT HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Fluocinolone Acetonide

### **Products Affected**

• fluocinolone acetonide external cream

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alclometasone cream/ointment
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Fluocinolone Acetonide

### **Products Affected**

• fluocinolone acetonide external ointment

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Fluocinonide

**Products Affected**fluocinonide external cream

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Fluocinonide

### **Products Affected**

- fluocinonide external cream
- fluocinonide external gel

• fluocinonide external ointment

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Fluocinonide

**Products Affected**fluocinonide external solution

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

### 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 09, 2018

**Products Affected**fluoxetine hcl oral capsule 10 mg

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

### **Products Affected**

• fluoxetine hcl oral capsule 20 mg

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

Products Affected
• fluoxetine hcl oral capsule 40 mg

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

### **Products Affected**

• fluoxetine hcl oral capsule delayed release

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

Products Affected
• fluoxetine hcl oral tablet 10 mg

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

### **Products Affected**

• fluoxetine hcl oral tablet 20 mg

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

Products Affected
• fluoxetine hcl oral tablet 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

# **Fluticasone Propionate**

### **Products Affected**

• fluticasone propionate external cream

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 mcglact, 232-14 mcglact, 55-14 mcglact

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

## Fluvastatin Sodium

### **Products Affected**

• fluvastatin sodium

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

### Fluvastatin Sodium ER

### **Products Affected**

• fluvastatin sodium er

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

### FluvoxaMINE Maleate

### **Products Affected**

• fluvoxamine maleate oral tablet 100 mg

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

### FluvoxaMINE Maleate

### **Products Affected**

• fluvoxamine maleate oral tablet 25 mg, 50 mg

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

# **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 D15g Blood Glucose Test

### **Products Affected**

FORA D15G BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **FORA D20 Blood Glucose Test**

### **Products Affected**

• FORA D20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **FORA G20 Blood Glucose Test**

### **Products Affected**

FORA G20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### FORA G30/Prem V10 Glucose Test

### **Products Affected**

 FORA G30/PREM V10 GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Fora GD20 Test

### **Products Affected**

### FORA GD20 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **FORA V10 Blood Glucose Test**

### **Products Affected**

FORA V10 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **FORA V12 Blood Glucose Test**

### **Products Affected**

FORA V12 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **FORA V20 Blood Glucose Test**

### **Products Affected**

FORA V20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### FORA V30a Blood Glucose Test

### **Products Affected**

• FORA V30A BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### ForaCare GD40 Test

### **Products Affected**

• FORACARE GD40 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ForaCare premium V10 Test

### **Products Affected**

• FORACARE PREMIUM V10 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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/bon e_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/bon e_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

### Fosamax Plus D

### **Products Affected**

FOSAMAX PLUS D

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	4 tabs Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 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

# **Frovatriptan Succinate**

### **Products Affected**

• frovatriptan succinate

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	9 tablets Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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

# **Fycompa**

### **Products Affected**

FYCOMPA ORAL TABLET

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

### **Products Affected**

• gabapentin oral capsule

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

### **Products Affected**

• gabapentin oral solution 250 mg/5ml

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

### **Products Affected**

• gabapentin oral solution 300 mg/6ml

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

### **Products Affected**

• gabapentin oral tablet

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

# 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/gal afold.html
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
<b>Covered Uses</b>	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

## **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 AffectedGATTEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Gatt ex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 30 fillss
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **GE100 Blood Glucose Test**

### **Products Affected**

GE100 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gelnique

Products AffectedGELNIQUE TRANSDERMAL GEL 10

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ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR and through either Vesicare or Myrbetriq
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Gelnique Pump**

Products AffectedGELNIQUE PUMP

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR and through either Vesicare or Myrbetriq
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Genotropin

### **Products Affected**

### GENOTROPIN

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

# Genotropin MiniQuick

Products AffectedGENOTROPIN MINIQUICK

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

# Genvoya

### **Products Affected**

GENVOYA

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

## Giazo

### **Products Affected**

• GIAZO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of balsalazide
QL Criteria	6 tabs Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 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/Gilen ya.html
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

## 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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Glatiramer Acetate**

### **Products Affected**

• glatiramer acetate

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/glatir amer.html
Exclusion Criteria	
Required Medical Information	
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

# Glatopa

### **Products Affected**

GLATOPA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/glatir amer.html
Exclusion Criteria	
Required Medical Information	
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

## Gleostine

### **Products Affected**

### • GLEOSTINE

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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month.

12/01/2019

# GlucaGen Diagnostic

### **Products Affected**

GLUCAGEN DIAGNOSTIC

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

# GlucaGen HypoKit

### **Products Affected**

GLUCAGEN HYPOKIT

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

# **Glucagon Emergency**

### **Products Affected**

GLUCAGON EMERGENCY

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

## **Glucocard 01 Sensor Plus**

### **Products Affected**

### • GLUCOCARD 01 SENSOR PLUS

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Glucocard Expression Test**

### **Products Affected**

### GLUCOCARD EXPRESSION TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Glucocard Vital Test**

### **Products Affected**

### GLUCOCARD VITAL TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Glucocard X-Sensor**

### **Products Affected**

### • GLUCOCARD X-SENSOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **GlucoCom Test**

### **Products Affected**

### GLUCOCOM TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glyxambi

### **Products Affected**

GLYXAMBI

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Tradjenta or Jentadueto and either Januvia or Janumet
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Gonal-f

### **Products Affected**

· GONAL-F

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/infer tility.html
Exclusion Criteria	
Required Medical Information	
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

### **Gonal-f RFF**

### **Products Affected**

• GONAL-F RFF

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

# **Gonal-f RFF Rediject**

### **Products Affected**

• GONAL-F RFF REDIJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 pack Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 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 Claritin OTC, Zyrtec OTC, or Allegra OTC
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month.

12/01/2019

## **GuanFACINE HCI ER**

#### **Products Affected**

• guanfacine hcl er

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

# 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/here ditary_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/here ditary_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 09, 2018

# **Halobetasol Propionate**

#### **Products Affected**

- halobetasol propionate external cream
- halobetasol propionate external ointment

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	50 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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/Harvon i.html
Exclusion Criteria	
Required Medical Information	
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

## **Helixate FS**

#### **Products Affected**

#### HELIXATE FS

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

# 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

## 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

## Horizant

#### **Products Affected**

 HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG

ST Criteria	FOR POST-HERPTIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of gabapentin. FOR RESTLESS LESG SYNDROME: A documented contraindication, intolerance, allergy, or failure of pramipexole or ropinirole.
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Horizant

#### **Products Affected**

 HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG

ST Criteria	FOR POST-HERPTIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of gabapentin. FOR RESTLESS LESG SYNDROME: A documented contraindication, intolerance, allergy, or failure of pramipexole or ropinirole.
QL Criteria	1 tablet Per 2 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Humatrope

### **Products Affected**

### HUMATROPE

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

#### **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: August 25, 2015

#### **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 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

#### **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: August 25, 2015

#### **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 injections 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 injections 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: August 25, 2015

## **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: August 25, 2015

# **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: August 25, 2015

## **Humira Pen**

#### **Products Affected**

 HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML

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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month.

12/01/2019

## 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 injections 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

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

# Hydrocodone-Acetaminophen

#### **Products Affected**

 hydrocodone-acetaminophen oral 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 2.5-325 mg, 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-guaiFENesin

#### **Products Affected**

• hydrocodone-guaifenesin

PA Criteria	Criteria Details
Covered Uses	Safety PA:  a. The member is aged 18 years or older  AND  b. 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  c. The member has tried and failed at least one non-opioid containing cough and cold remedy  Safety QL: 300ml/month
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 or older
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
QL Criteria	60 ml Per 1 day over 5 days in a 30 day period
Notes/ References	
Revision Date	Prior Authorization: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA: FL

### 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 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

2019 Aetna Small Group ACA: FL

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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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

2019 Aetna Small Group ACA: FL

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

2019 Aetna Small Group ACA: FL

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	
QL Criteria	5 vials Per 1 year
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 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 HYSINGI A FR

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

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 oral

PA Criteria	Criteria Details
<b>Covered Uses</b>	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	A documented diagnosis of osteoporosis
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 alendronate weekly 70mg
QL Criteria	1 tab Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 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 capsules Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Ibudone**

#### **Products Affected**

• ibudone oral tablet 5-200 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological 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 Small Group ACA: FL

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

### **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/here ditary_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: August 25, 2015

### **Iclusig**

#### **Products Affected**

• ICLUSIG ORAL TABLET 15 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 tabs 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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 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/Ilar is.html
Exclusion Criteria	
Required Medical Information	
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

### **Ilaris (150mg Delivered)**

#### **Products Affected**

• ILARIS (150MG DELIVERED)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Ilar is.html
Exclusion Criteria	
Required Medical Information	
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

### **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

# Imiquimod

#### **Products Affected**

imiquimod external

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

### **Impavido**

#### **Products Affected**

#### IMPAVIDO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Leishmaniasis
Exclusion Criteria	Known or suspected pregnancy
Required Medical Information	A documented diagnosis of any of the following leishmaniasis infections: Visceral leishmaniasis due to Leishmania donovani, Cutaneous leishmaniasis due to Leishmania braziliensis, Leishmania guyanensis, and Leishmania panamensis, or Mucosal leishmaniasis due to Leishmania braziliensis
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	28 days
Other Criteria	
QL Criteria	3 caps Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 16, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **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/Inc relex.html
Exclusion Criteria	
Required Medical Information	
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

## **Incruse Ellipta**

#### **Products Affected**

• INCRUSE ELLIPTA

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

### Indomethacin

#### **Products Affected**

indomethacin oral

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

# **Infinity Blood Glucose Test**

#### **Products Affected**

INFINITY BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ingrezza

#### **Products Affected**

• INGREZZA ORAL CAPSULE 40 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 09, 2018

# Ingrezza

#### **Products Affected**

• INGREZZA ORAL CAPSULE 80 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 09, 2018

# Inlyta

#### **Products Affected**

INLYTA

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

# **Inrebic**

#### **Products Affected**

INREBIC

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

### Intelence

#### **Products Affected**

 INTELENCE ORAL TABLET 100 MG, 25 MG

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

### **Intelence**

#### **Products Affected**

• INTELENCE ORAL TABLET 200 MG

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

### **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

# **Invokamet**

#### **Products Affected**

INVOKAMET

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

### **Invokamet XR**

#### **Products Affected**

INVOKAMET XR

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

# Invokana

#### **Products Affected**

INVOKANA

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

# **Ipratropium Bromide**

#### **Products Affected**

• ipratropium bromide nasal

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

### Irbesartan

#### **Products Affected**

• irbesartan

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

# Irbesartan-Hydrochlorothiazide

#### **Products Affected**

• irbesartan-hydrochlorothiazide

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

### **Isentress**

#### **Products Affected**

ISENTRESS ORAL TABLET

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

### **Isentress**

#### **Products Affected**

 ISENTRESS ORAL TABLET CHEWABLE

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

### **Isentress HD**

#### **Products Affected**

• ISENTRESS HD

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

# **ISOtretinoin**

#### **Products Affected**

• isotretinoin oral

PA Criteria	Criteria Details
<b>Covered Uses</b>	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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Itraconazole

#### **Products Affected**

• itraconazole oral capsule

PA Criteria	Criteria Details
Covered Uses	Onychomycosis, invasive fungal infection, other fungal infection, superficial mycoses
Exclusion Criteria	Cosmetic use, patients with evidence of ventricular dysfunction such as CHF or a history of CHF. Coadministration with certain drugs metabolized by the cytochrome P-450 3A4 isoenzyme system (CYP3A4), cisapride, oral midazolam, pimozide, quinidine, dofetilide, triazolam, HMG-CoA reductase inhibitors metabolized by CYP3A4, such as lovastatin and simvastatin, and ergot alkaloids metabolized by CYP3A4, such as dihydroergotamine, ergotamine, ergonovine, and methylergonovine.
Required Medical Information	Itraconazole is covered for members who meet the following criteria: Invasive fungal infections in patients who are immunocompromised (such as histoplamosis, aspergillosis, and blastomycosis), treatment of tinea barbae, tinea capitis, tinea favosa, tinea corporis, tinea cruris, tinea faciei, tinea manuum, or tinea pedis, a diagnosis of majocchi granuloma, or a diagnosis of onychomycosis in diabetic patients or patients with peripheral vascular disease and either a positive onychomycosis susceptible pathogen culture or a positive PAS stain performed by a laboratory, or a diagnosis of onychomycosis with documented disabling pain or impairment and a positive onychomycosis susceptible pathogen culture
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Nail: 12 wk(toe),5 wk (finger) per year,Invasive: 1-3 mo based on severity, Other Dx: 1-6 wk
Other Criteria	

ST Criteria	FOR A DIAGNOSIS OF ONYCHOMYCOSIS, TINEA BARBAE, TIBNEA CAPITIS, TINEA FAVOSA: A documented contraindication, intolerance, allergy, or failure of terbinafine. FOR A DIAGNOSIS OF TINEA CORPORIS, TINEA CRURIS, TINEA FACIEI, TINEA MANUUM, TINEA PEDIS: A documented contraindication, intolerance, allergy, or failure of a topical antifungal and terbinafine. FOR A DIAGNOSIS OF TINEA VERSICOLOR: A documented contraindication, intolerance, allergy, or failure of selenium sulfide and a topical antifungal.
QL Criteria	4 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 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: August 25, 2015

### Jakafi

#### **Products Affected**

 JAKAFI ORAL TABLET 15 MG, 20 MG, 25 MG, 5 MG

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

### Janumet XR

#### **Products Affected**

 JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-500 MG

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

### Janumet XR

#### **Products Affected**

 JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG

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

# Januvia

#### **Products Affected**

JANUVIA

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

# **Jardiance**

#### **Products Affected**

JARDIANCE

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

# Jentadueto

#### **Products Affected**

JENTADUETO

QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Jentadueto XR

#### **Products Affected**

 JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Jentadueto XR

#### **Products Affected**

 JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Jublia

#### **Products Affected**

JUBLIA

PA Criteria	Criteria Details
Covered Uses	Onychomycosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Failure of an adequate trial of one systemic oral alternative is terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail), OR If member has hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or is female and is pregnant and/or breastfeeding. (No trial needed)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one systemic (oral) alternative such as terbinafine, itraconazole, griseofulvin
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

# 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: August 25, 2015

# Juxtapid

#### **Products Affected**

#### JUXTAPID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/Antilipi demic_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/Antilipi demic_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/Jyna rque.html
Exclusion Criteria	
Required Medical Information	
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 200 MG, 40 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 extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# 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 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 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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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, griseofulvin
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

### Ketoconazole

#### **Products Affected**

ketoconazole external foam

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

### Ketoconazole

#### **Products Affected**

ketoconazole oral

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

### **Ketorolac Tromethamine**

#### **Products Affected**

• ketorolac tromethamine oral

QL Criteria	20 tablets Per 5 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: 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/Kin eret.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Kin eret.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

# **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

# **Kogenate FS Bio-Set**

#### **Products Affected**

KOGENATE FS BIO-SET

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

# Kombiglyze XR

#### **Products Affected**

 KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Tradjenta or Jentadueto and either Januvia or Janumet
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Kombiglyze XR

#### **Products Affected**

 KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG, 5-500 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Tradjenta or Jentadueto and either Januvia or Janumet
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 tabs Per 1 Day
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

### 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/meta bolic_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

# LamoTRIgine

#### **Products Affected**

• lamotrigine oral tablet dispersible 100 mg, 200 mg

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

# LamoTRIgine

#### **Products Affected**

• lamotrigine oral tablet dispersible 25 mg

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

# LamoTRIgine

#### **Products Affected**

• lamotrigine oral tablet dispersible 50 mg

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

# LamoTRIgine ER

#### **Products Affected**

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

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

# **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

# Lansoprazole

#### **Products Affected**

lansoprazole oral capsule delayed release 15 mg

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

### Lansoprazole

#### **Products Affected**

lansoprazole oral capsule delayed release 30 mg

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

# Lansoprazole

#### **Products Affected**

• lansoprazole oral tablet dispersible

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

### Lantus

#### **Products Affected**

LANTUS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Lantus SoloStar

#### **Products Affected**

 LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### 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 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: September 07, 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: September 07, 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: September 07, 2018 Quantity Limits: August 25, 2015

### Leflunomide

**Products Affected**• leflunomide oral

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

### 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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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

### **Levalbuterol Tartrate**

#### **Products Affected**

levalbuterol tartrate

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Ventolin HFA
QL Criteria	2 inhalers Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### LevETIRAcetam ER

#### **Products Affected**

levetiracetam er oral tablet extended release
 24 hour 500 mg

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

### LevETIRAcetam ER

#### **Products Affected**

levetiracetam er oral tablet extended release
 24 hour 750 mg

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

## **Levorphanol Tartrate**

#### **Products Affected**

• levorphanol tartrate oral 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

2019 Aetna Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	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

## **Liberty Next Generation Test**

#### **Products Affected**

LIBERTY NEXT GENERATION TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Liberty Test**

#### **Products Affected**

### LIBERTY TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Lidocaine

#### **Products Affected**

• lidocaine 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

## **Lidocaine PAK**

#### **Products Affected**

• lidocaine pak

QL Criteria	90 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Lidocaine-Prilocaine

#### **Products Affected**

• lidocaine-prilocaine external cream

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

## 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of lactulose or polyethylene glycol
QL Criteria	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Linzess

#### **Products Affected**

#### LINZESS ORAL CAPSULE 72 MCG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of lactulose or polyethylene glycol
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Livalo

#### **Products Affected**

LIVALO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastatin
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 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

## 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

2019 Aetna Small Group ACA: FL

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	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 Small Group ACA: FL

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	

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

## **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

### Lovastatin

#### **Products Affected**

• lovastatin

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

## 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 05, 2018

### Lucentis

#### **Products Affected**

 LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE 0.3 MG/0.05ML

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Lupaneta Pack

#### **Products Affected**

LUPANETA PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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

## Lyrica CR

#### **Products Affected**

 LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 165 MG, 82.5 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	A diagnosis of epilepsy as adjunct therapy, diabetic peripheral neuropathy, post-herpetic neuropathy, Fibromyalgia with failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), or for neuropathic pain associated with spinal cord injury
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation of disease stability or improvement in symptoms from baseline.

ST Criteria	FOR A DIAGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY OR POST-HERPETIC NEUROPATHY: A documented contraindication, intolerance, allergy, or failure of gabapentin or pregablin. FOR A DIAGNOSIS OF FIBROMYALGIA: A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SSRI, SNRI, gabapentin, pregablin or tramadol. FOR A DIAGNOSIS OF NEUROPATHIC PAIN ASSOCIATED WITH SPINAL CORD INJURY: A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SNRI, gabapentin, or tramadol.
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: September 08, 2019 Quantity Limits: August 25, 2015

# Lyrica CR

### **Products Affected**

 LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 330 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	A diagnosis of epilepsy as adjunct therapy, diabetic peripheral neuropathy, post-herpetic neuropathy, Fibromyalgia with failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), or for neuropathic pain associated with spinal cord injury
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation of disease stability or improvement in symptoms from baseline.

ST Criteria	FOR A DIAGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY OR POST-HERPETIC NEUROPATHY: A documented contraindication, intolerance, allergy, or failure of gabapentin or pregablin. FOR A DIAGNOSIS OF FIBROMYALGIA: A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SSRI, SNRI, gabapentin, pregablin or tramadol. FOR A DIAGNOSIS OF NEUROPATHIC PAIN ASSOCIATED WITH SPINAL CORD INJURY: A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SNRI, gabapentin, or tramadol.
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: September 08, 2019 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/hyd roxyprogesterone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	21 syringes Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Maprotiline HCl**

### **Products Affected**

• maprotiline hcl oral tablet 25 mg

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

# **Maprotiline HCl**

### **Products Affected**

• maprotiline hcl oral tablet 50 mg

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

# **Maprotiline HCl**

### **Products Affected**

• maprotiline hcl oral tablet 75 mg

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

## **Matzim LA**

### **Products Affected**

• matzim la oral tablet extended release 24 hour 180 mg, 300 mg, 360 mg

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

## **Matzim LA**

### **Products Affected**

 matzim la oral tablet extended release 24 hour 240 mg

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

## Mavyret

### **Products Affected**

### MAVYRET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Mavyre t.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Mavyre t.html
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

## MedroxyPROGESTERone Acetate

### **Products Affected**

• medroxyprogesterone acetate intramuscular suspension prefilled syringe

QL Criteria	1 syringe Per 90 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### 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 tabs 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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Memantine HCl**

### **Products Affected**

- memantine hcl oral solution 2 mg/ml
- memantine hcl oral tablet

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

## **Memantine HCl ER**

### **Products Affected**

• memantine hcl er

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

## Menostar

### **Products Affected**

MENOSTAR

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

# **Meperidine HCl**

### **Products Affected**

• meperidine hcl oral 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

2019 Aetna Small Group ACA: FL

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

# **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

2019 Aetna Small Group ACA: FL

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	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

### **Products Affected**

• mesalamine oral capsule delayed release

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

### **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

### **Products Affected**

mesalamine oral tablet delayed release 800 mg

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

### **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 tabs Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## metFORMIN HCl ER (OSM)

### **Products Affected**

• metformin hcl er (osm) oral tablet extended release 24 hour 1000 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of both generic Glucophage and generic Glucophage XR
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# MetFORMIN HCl ER (OSM)

### **Products Affected**

• metformin hcl er (osm) oral tablet extended release 24 hour 500 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of both generic Glucophage and generic Glucophage XR
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Methadone HCl**

### **Products Affected**

• methadone hcl oral concentrate

PA Criteria	Criteria Details
<b>Covered Uses</b>	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).
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
<b>Covered Uses</b>	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).
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
<b>Covered Uses</b>	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).
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
<b>Covered Uses</b>	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).
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
<b>Covered Uses</b>	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).
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
<b>Covered Uses</b>	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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

### Methadose

#### **Products Affected**

 METHADOSE ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
<b>Covered Uses</b>	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).
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.
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
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	4 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Methergine

#### **Products Affected**

METHERGINE ORAL

QL Criteria	28 tablets Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Products Affected**

 methylphenidate hcl oral solution 10 mg/5ml

QL Criteria	30 ML Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

#### **Products Affected**

• methylphenidate hcl oral solution 5 mg/5ml

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

### **Products Affected**

• methylphenidate hcl 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

#### **Products Affected**

• methylphenidate hcl oral tablet chewable

QL Criteria	6 tablets Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

#### **Products Affected**

 methylphenidate hcl er oral tablet extended release 10 mg

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

#### **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

#### **Products Affected**

 methylphenidate hcl er oral tablet extended release 20 mg

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

#### **Products Affected**

 methylphenidate hcl er oral tablet extended release 36 mg

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

#### **Products Affected**

 methylphenidate hcl er oral tablet extended release 72 mg

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

#### **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

#### **Products Affected**

 methylphenidate hcl er oral tablet extended release 24 hour 36 mg

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

# Methylphenidate HCl ER (CD)

### **Products Affected**

• methylphenidate hcl er (cd)

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

# Methylphenidate HCl ER (LA)

#### **Products Affected**

• methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 60 mg

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

# Methylphenidate HCl ER (LA)

#### **Products Affected**

• methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 30 mg, 40 mg

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

### **Metoprolol Succinate ER**

#### **Products Affected**

• metoprolol succinate er oral tablet extended release 24 hour 100 mg, 50 mg

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

# **Metoprolol Succinate ER**

#### **Products Affected**

• metoprolol succinate er oral tablet extended release 24 hour 200 mg

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

### **Metoprolol Succinate ER**

#### **Products Affected**

 metoprolol succinate er oral tablet extended release 24 hour 25 mg

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

### **Microdot Test**

#### **Products Affected**

MICRODOT TEST

QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
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/gau cher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/gau cher_disease.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

### **Mimvey**

#### **Products Affected**

mimvey

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

# **Mimvey Lo**

#### **Products Affected**

MIMVEY LO

QL Criteria	1 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/Eryt hropoiesis_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 tablet

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

## Mirtazapine

#### **Products Affected**

• mirtazapine oral tablet dispersible

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

### Mirvaso

#### **Products Affected**

#### MIRVASO

PA Criteria	Criteria Details
Covered Uses	Topical treatment of persistent (nontransient) facial erythema associated with rosacea in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of ersistent (nontransient) facial erythema associated with rosacea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of metronidazole gel and metronidazole cream 0.75%
Notes/ References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Modafinil

#### **Products Affected**

modafinil

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

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria: A documented diagnosis of Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), or Shift Work Sleep Disorder AND FOR NARCOLEPSY AND OSAHS: There is clinical documentation demonstrating reduction in baseline symptoms of excessive daytime sleepiness AND FOR SHIFT WORK SLEEP DISORDER: There is clinical documentation demonstrating reduction in baseline symptoms of excessive sleepiness or difficulty sleeping
ST Criteria	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: A documented contraindication, intolerance, allergy, or failure of an adequate trial of at least two immediate release stimulants.
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Mometasone Furoate**

#### **Products Affected**

- mometasone furoate external cream
- mometasone furoate external ointment

ST Criteria	A documented contraindication, intolerance, allergy, or failure of triamcinolone (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Montelukast Sodium**

#### **Products Affected**

montelukast sodium oral packet

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

### **Montelukast Sodium**

#### **Products Affected**

- montelukast sodium oral tablet
- montelukast sodium oral tablet chewable

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

## **Morphine Sulfate**

#### **Products Affected**

• morphine sulfate oral solution 10 mg/5ml

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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	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 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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on 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 extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on 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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

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 extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 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/M ozobil.html
Exclusion Criteria	
Required Medical 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

# 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 AffectedMULTAQ

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

# Mupirocin

#### **Products Affected**

• mupirocin external

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

# **Mupirocin Calcium**

### **Products Affected**

• mupirocin calcium

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

# Myalept

#### **Products Affected**

MYALEPT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/My alept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	15 vials Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# MyGlucoHealth Test

#### **Products Affected**

### MYGLUCOHEALTH TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Myrbetriq

# Products AffectedMYRBETRIQ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Mytesi

### **Products Affected**

### MYTESI

PA Criteria	Criteria Details
Covered Uses	Non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy
Exclusion Criteria	
Required Medical Information	Covered for adult members who have a documented diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month and who are currently stable on anti-retroviral therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of at least one antimotility agent such as loperamide or atropine/diphenoxylate
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Naftifine HCl**

#### **Products Affected**

• naftifine hcl external cream 1 %

ST Criteria	A documented contraindication, intolerance, allergy, or failure of clotrimazole and econazole 1%
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Naftifine HCl**

#### **Products Affected**

• naftifine hcl external cream 2 %

ST Criteria	A documented contraindication, intolerance, allergy, or failure of clotrimazole and econazole 1%
QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Naftin

#### **Products Affected**

NAFTIN EXTERNAL GEL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of clotrimazole and econazole 1%
QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Namenda XR

#### **Products Affected**

### NAMENDA XR

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

## **Namenda XR Titration Pack**

#### **Products Affected**

### NAMENDA XR TITRATION PACK

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

## Namzaric

#### **Products Affected**

NAMZARIC

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

# Naratriptan HCl

#### **Products Affected**

• naratriptan hcl

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

# **Nasacort Allergy 24HR**

#### **Products Affected**

NASACORT ALLERGY 24HR

QL Criteria	1 bottle Per 1 month
Notes/ References	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 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	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 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	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: gabapentin, Ropinirole, pramipexole (covered without trials of Parkinson's)
QL Criteria	1 patch Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Neutek 2Tek Test

#### **Products Affected**

• NEUTEK 2TEK TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Nevirapine ER**

#### **Products Affected**

 nevirapine er oral tablet extended release 24 hour 100 mg

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

## **Nevirapine ER**

#### **Products Affected**

 nevirapine er oral tablet extended release 24 hour 400 mg

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

### **NexAVAR**

#### **Products Affected**

### NEXAVAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 tabs 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	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barretts Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole (not required for Nexium Packet requests for members under one year of age)
QL Criteria	1 packet Per 1 Day
Notes/ References	Annual Review: 02/2017

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015
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### NexIUM 24HR

#### **Products Affected**

 NEXIUM 24HR 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

### 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

## **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: March 19, 2019

## **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 19, 2019

## **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

## Nifediac CC

#### **Products Affected**

 nifediac cc 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

## Nifedical XL

#### **Products Affected**

 nifedical xl oral tablet extended release 24 hour 60 mg

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

## **NIFEdipine ER**

### **Products Affected**

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

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

# **NIFEdipine ER**

#### **Products Affected**

• nifedipine er oral tablet extended release 24 hour 60 mg

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

# NIFEdipine ER Osmotic Release

#### **Products Affected**

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

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

# NIFEdipine ER Osmotic Release

#### **Products Affected**

• nifedipine er osmotic release oral tablet extended release 24 hour 60 mg

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

# **Nisoldipine ER**

#### **Products Affected**

• nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 34 mg, 40 mg, 8.5 mg

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

# **Nisoldipine ER**

#### **Products Affected**

• nisoldipine er oral tablet extended release 24 hour 30 mg

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

## **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/meta bolic_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

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

# Norditropin FlexPro

#### **Products Affected**

### NORDITROPIN FLEXPRO

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

## **Nova Max Glucose Test**

#### **Products Affected**

NOVA MAX GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Novarel

#### **Products Affected**

 NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/infer tility.html
Exclusion Criteria	
Required Medical Information	
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

## **NovoLOG**

#### **Products Affected**

### NOVOLOG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## NovoLOG FlexPen

#### **Products Affected**

 NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## NovoLOG Mix 70/30

#### **Products Affected**

• NOVOLOG MIX 70/30

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### NovoLOG Mix 70/30 FlexPen

#### **Products Affected**

 NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## NovoLOG PenFill

#### **Products Affected**

 NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Noxafil

#### **Products Affected**

### NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of Invasive Aspergillosis, prophylaxis of invasive candidiasis, treatment of oropharyngeal candidiasis in patients with disease refractory
Exclusion Criteria	Noxafil is NOT covered for members who are pursuing for prophylaxis of invasive aspergillosis or candidiasis who are not severely immunocompromised, for patients less that 13 years of age, patients without refractory disease to first-line antifungal agents, concomitant use with ergot alkaloids, simvastatin, or sirolimus, or concomitant use with CYP3A4 substrates such as, pimozide and quinidine.
Required Medical Information	Noxafil is covered for members who meet any ONE of the following criteria: (1) Prophylaxis of Invasive Aspergillosis in severely immunocompromised patients with active disease, (2) Prophylaxis of Invasive Candidiasis in severely immunocompromised patients, or (3) Treatment of Oropharyngeal Candidiasis
Age Restrictions	13 years of age or greater
Prescriber Restrictions	
Coverage Duration	Invasive Aspergillosis/Candidiasis prophylaxis- 3 months, Oropharyngeal Candidiasis-13 days
Other Criteria	Refractory fungal infection is defined as a previous occurrence of disease which failed to improve or respond to a standard course of antifungal therapy. Patients started on Noxafil as an inpatient will be allowed to continue therapy on an outpatient basis without interruption. Initial therapy of one 105ml bottle (7-day supply) will be covered to assure that therapy is not delayed while the prior authorization request is being reviewed.

ST Criteria	FOR A DIAGNOSIS OF INVASIVE CANDIDIASIS: A documented contraindication, intolerance, allergy, or failure of fluconazole. FOR A DIAGNOSIS OF OROPHARYNGEAL CANDIDIASIS: A documented contraindication, intolerance, allergy, or failure of fluconazole or itraconazole
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Nplate**

#### **Products Affected**

NPLATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/npla te.html
Exclusion Criteria	
Required Medical Information	
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

# 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

2019 Aetna Small Group ACA: FL

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: June 05, 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

2019 Aetna Small Group ACA: FL

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: June 05, 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

2019 Aetna Small Group ACA: FL

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: June 05, 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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

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 DIGANOSIS OF CHRONIC PAIN: A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin). FOR A DIGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY (DPN): 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 caps 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

# 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

## Octagam

#### **Products Affected**

 OCTAGAM INTRAVENOUS SOLUTION 30 GM/300ML

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/San dostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Odefsey

### **Products Affected**

ODEFSEY

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

### Odomzo

### **Products Affected**

### · ODOMZO

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

## **Ofloxacin**

Products Affected
• ofloxacin oral tablet 300 mg

QL Criteria	28 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **OLANZapine**

### **Products Affected**

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

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

# **OLANZapine**

### **Products Affected**

• olanzapine oral tablet 2.5 mg

QL Criteria	2 tabs 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 dispersible 10 mg

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

# **OLANZapine-FLUoxetine HCl**

### **Products Affected**

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

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

### 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	
<b>Revision Date</b>	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/Olu miant.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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: August 25, 2015

# Olysio

### **Products Affected**

OLYSIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Olysio. html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Olysio.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

# **Omega-3-acid Ethyl Esters**

### **Products Affected**

• omega-3-acid ethyl esters

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

# **Omeprazole-Sodium Bicarbonate**

### **Products Affected**

• omeprazole-sodium bicarbonate oral capsule

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

### **Omnaris**

### **Products Affected**

### OMNARIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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

### On Call Plus Blood Glucose

### **Products Affected**

### ON CALL PLUS BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### On Call Vivid Blood Glucose

### **Products Affected**

• ON CALL VIVID BLOOD GLUCOSE

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **OneTouch Ultra Blue**

### **Products Affected**

ONETOUCH ULTRA BLUE

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

### **OneTouch Verio**

### **Products Affected**

ONETOUCH VERIO IN VITRO STRIP

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

# Onglyza

### **Products Affected**

ONGLYZA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Tradjenta or Jentadueto and either Januvia or Janumet
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Opana ER**

#### **Products Affected**

 OPANA ER ORAL TABLET ER 12 HOUR ABUSE-DETERRENT

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

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 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/pulmon aryhypertensionagents.html
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

# **Oravig**

### **Products Affected**

ORAVIG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of fluconazole, and either nystatin or clotrimazole troche
QL Criteria	14 tabs Per 1 fill
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 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/Ore ncia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Ore ncia.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/Ore ncia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Ore ncia.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/Ore ncia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Ore ncia.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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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/meta bolic_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/Gon adotropins.html
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/day Per 730 lifetime days
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 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/Gon adotropins.html
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/day Per 180 lifetime days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### 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, 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 tablets Per 1 Day
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: August 25, 2015

### **Osphena**

#### **Products Affected**

#### OSPHENA

PA Criteria	Criteria Details
<b>Covered Uses</b>	moderate to severe dyspareunia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe dyspareunia in a female patient
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an estrogen product such as estradiol, estropipate, or Premarin
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 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/Ote zla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Ote zla.html
QL Criteria	2 tablets Per 1 Day
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/Ote zla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Ote zla.html
QL Criteria	1 pack Per 1 year
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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	

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

### 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	

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

### 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/ophth almic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ml Per 1 day and 112 ml per lifetime
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Oxiconazole Nitrate**

#### **Products Affected**

• oxiconazole nitrate

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

### Oxistat

#### **Products Affected**

OXISTAT EXTERNAL LOTION

QL Criteria	60 ml Per 30 Days
Notes/ References	
<b>Revision Date</b>	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 150 MG, 300 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of immediate release oxcarbazepine
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Oxtellar XR

#### **Products Affected**

 OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 600 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of immediate release oxcarbazepine
QL Criteria	4 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Oxybutynin Chloride**

#### **Products Affected**

• oxybutynin chloride oral tablet

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

## **Oxybutynin Chloride ER**

#### **Products Affected**

• oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Oxybutynin Chloride ER**

#### **Products Affected**

 oxybutynin chloride er oral tablet extended release 24 hour 5 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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

2019 Aetna Small Group ACA: FL

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

2019 Aetna Small Group ACA: FL

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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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

2019 Aetna Small Group ACA: FL

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

2019 Aetna Small Group ACA: FL

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-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

2019 Aetna Small Group ACA: FL

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	12 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 10 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: June 05, 2018 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

2019 Aetna Small Group ACA: FL

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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: June 05, 2018 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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

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 extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Oxytrol For Women**

#### **Products Affected**

OXYTROL FOR WOMEN

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

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

### **Pancreaze**

### **Products Affected**

### PANCREAZE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **PARoxetine HCl**

#### **Products Affected**

• paroxetine hcl oral tablet 30 mg, 40 mg

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

### **PARoxetine HCl ER**

#### **Products Affected**

• paroxetine hcl er

ST Criteria	A documented contraindication, intolerance, allergy, or failure of paroxetine
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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

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/meta bolic_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

### Pentasa

#### **Products Affected**

 PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Apriso
QL Criteria	16 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Pentasa

#### **Products Affected**

 PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Apriso
QL Criteria	8 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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

2019 Aetna Small Group ACA: FL

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	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.
QL Criteria	60 vials Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Pertzye**

#### **Products Affected**

#### • PERTZYE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Pharmacist Choice Autocode**

#### **Products Affected**

• PHARMACIST CHOICE AUTOCODE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Phendimetrazine Tartrate**

#### **Products Affected**

• phendimetrazine tartrate

QL Criteria	6 tablets Per 1 Day
Notes/ References	Annual Review: 04/2017
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 05, 2019

### **Phentermine HCl**

#### **Products Affected**

• phentermine hcl oral capsule 15 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Phentermine HCl**

#### **Products Affected**

• phentermine hcl oral capsule 30 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

## **Phytonadione**

### **Products Affected**

• phytonadione oral

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

## **Picato**

# Products AffectedPICATO

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

## **Pimecrolimus**

#### **Products Affected**

• pimecrolimus

PA Criteria	Criteria Details
<b>Covered Uses</b>	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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month.

12/01/2019

# **Pioglitazone HCl**

### **Products Affected**

• pioglitazone hcl

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

# Pioglitazone HCl-Glimepiride

#### **Products Affected**

• pioglitazone hcl-glimepiride

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

# Pioglitazone HCl-Metformin HCl

#### **Products Affected**

• pioglitazone hcl-metformin hcl

QL Criteria	1 tablet 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)

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

# Piqray (250 MG Daily Dose)

#### **Products Affected**

• PIQRAY (250 MG DAILY DOSE)

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)

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

# **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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSIn terferons.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

# **Plegridy Starter Pack**

#### **Products Affected**

 PLEGRIDY STARTER PACK 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/CNS/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSIn terferons.html
QL Criteria	1 kit Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

# **Plegridy Starter Pack**

#### **Products Affected**

 PLEGRIDY STARTER 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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

## **PocketChem EZ Test**

#### **Products Affected**

• POCKETCHEM EZ TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 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	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Potiga

#### **Products Affected**

 POTIGA ORAL TABLET 200 MG, 300 MG, 400 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

## Potiga

#### **Products Affected**

POTIGA 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

## **Praluent**

#### **Products Affected**

 PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCS K9.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

# Pramipexole Dihydrochloride ER

### **Products Affected**

• pramipexole dihydrochloride 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

# **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

## **Pravastatin Sodium**

#### **Products Affected**

• pravastatin sodium

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

## **Precision PCx**

#### **Products Affected**

PRECISION PCX

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

## **Precision PCX Plus Test**

#### **Products Affected**

PRECISION PCX PLUS TEST

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

## **Precision Point of Care Test**

#### **Products Affected**

PRECISION POINT OF CARE TEST

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

# **Precision QID Test**

#### **Products Affected**

PRECISION QID TEST

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

## **Precision Sof-Tact Test**

#### **Products Affected**

PRECISION SOF-TACT TEST

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

## **Precision Xtra Blood Glucose**

#### **Products Affected**

PRECISION XTRA BLOOD GLUCOSE

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

## **Prefest**

#### **Products Affected**

PREFEST

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

## Pregabalin

#### **Products Affected**

• pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	A diagnosis of epilepsy as adjunct therapy, diabetic peripheral neuropathy, post-herpetic neuropathy, Fibromyalgia with failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), or for neuropathic pain associated with spinal cord injury
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation of disease stability or improvement in symptoms from baseline.
QL Criteria	3 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Pregabalin

#### **Products Affected**

• pregabalin oral capsule 225 mg, 300 mg

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	A diagnosis of epilepsy as adjunct therapy, diabetic peripheral neuropathy, post-herpetic neuropathy, Fibromyalgia with failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), or for neuropathic pain associated with spinal cord injury
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation of disease stability or improvement in symptoms from baseline.
QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Pregabalin

#### **Products Affected**

• pregabalin oral solution

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	A diagnosis of epilepsy as adjunct therapy, diabetic peripheral neuropathy, post-herpetic neuropathy, Fibromyalgia with failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), or for neuropathic pain associated with spinal cord injury
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation of disease stability or improvement in symptoms from baseline.
QL Criteria	30 ML Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Pregnyl

### **Products Affected**

• PREGNYL

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

## **Premium Lidocaine**

#### **Products Affected**

• premium lidocaine

QL Criteria	90 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Prevacid 24HR**

#### **Products Affected**

• PREVACID 24HR

QL Criteria	2 caps 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 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Prezista

#### **Products Affected**

 PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG

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

## Prezista

#### **Products Affected**

PREZISTA ORAL TABLET 800 MG

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

## **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/Eryt hropoiesis_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

## **Proctofoam HC**

### **Products Affected**

PROCTOFOAM HC

QL Criteria	20 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Prodigy No Coding Blood Gluc**

### **Products Affected**

 PRODIGY NO CODING BLOOD GLUC IN VITRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 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

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

## **Prolia**

### **Products Affected**

 PROLIA 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/bon e_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/bon e_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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 tab 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 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Propafenone HCl ER**

### **Products Affected**

• propafenone hcl er

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

## **Pulmicort Flexhaler**

### **Products Affected**

### • PULMICORT FLEXHALER

PA Criteria	Criteria Details
<b>Covered Uses</b>	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 QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 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	60 units Per 1 fill
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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Antineoplastics.html
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 Quantity Limits: August 25, 2015

## **Q**brexza

### **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	A documented diagnosis of primary axillary hyperhidrosis in adult and pediatric patients greater than 9 years old.
Information	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 Small Group ACA: FL

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 fluticasone propionate and flunisolide
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Qnasl Childrens**

### **Products Affected**

QNASL CHILDRENS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Qtern

### **Products Affected**

• QTERN ORAL TABLET 5-5 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

### **Products Affected**

quetiapine fumarate oral tablet 100 mg, 50 mg

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

### **Products Affected**

• quetiapine fumarate oral tablet 200 mg

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

### **Products Affected**

• quetiapine fumarate oral tablet 25 mg

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

### **Products Affected**

quetiapine fumarate oral tablet 300 mg, 400 mg

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

### **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
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

#### **Products Affected**

• quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 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

# **Quillivant XR**

### **Products Affected**

• QUILLIVANT XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	1 bottle Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: June 04, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Qvar

### **Products Affected**

 QVAR INHALATION AEROSOL SOLUTION

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

# **Qvar RediHaler**

### **Products Affected**

QVAR REDIHALER

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

# RABEprazole Sodium

### **Products Affected**

• rabeprazole sodium oral capsule sprinkle

QL Criteria	1 capsule per day, 90 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 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/doc uments/2019 PPI Post Limit QL Criteria_Updateddoc
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 Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole (not required for Nexium Packet requests for members under one year of age)
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 02/2017

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

<b>Revision Date</b>	Prior Authorization: November 21, 2016 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015
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## **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: August 25, 2015

# Rasagiline Mesylate

### **Products Affected**

• rasagiline mesylate oral

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

## 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/meta bolic_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/meta bolic_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

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

### 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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 titration pack Per 1 month
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/MSIn terferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 titration pack Per 1 month
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	30 grams Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **RefuAH Plus Blood Glucose Test**

### **Products Affected**

 REFUAH PLUS BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Regranex

### **Products Affected**

REGRANEX

QL Criteria	30 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: March 03, 2019

## Relenza Diskhaler

### **Products Affected**

RELENZA DISKHALER

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

## Relexxii

### **Products Affected**

RELEXXII

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

### Remodulin

#### **Products Affected**

 REMODULIN INJECTION SOLUTION 1 MG/ML, 10 MG/ML, 2.5 MG/ML, 5 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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

# **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/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCS K9.html
QL Criteria	2 injections 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/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCS K9.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

# 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/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCS K9.html
QL Criteria	2 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

### Rescula

### **Products Affected**

### RESCULA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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/Eryt hropoiesis_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

## **Reveal Blood Glucose Test**

### **Products Affected**

REVEAL BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Revlimid

### **Products Affected**

### REVLIMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 cap 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: September 07, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

# Reyataz

### **Products Affected**

 REYATAZ ORAL CAPSULE 150 MG, 300 MG

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

# Reyataz

### **Products Affected**

• REYATAZ ORAL CAPSULE 200 MG

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

# 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: June 05, 2018 Quantity Limits: August 25, 2015

# Rightest GS100 Blood Glucose

### **Products Affected**

### RIGHTEST GS100 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS300 Blood Glucose

### **Products Affected**

RIGHTEST GS300 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS550 Blood Glucose

### **Products Affected**

### • RIGHTEST GS550 BLOOD GLUCOSE

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 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

### **Products Affected**

• risedronate sodium oral tablet 150 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	1 tablet Per 28 Days
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Products Affected**

• risedronate sodium oral tablet 30 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: May 08, 2019

### **Products Affected**

• risedronate sodium oral tablet 35 mg

release

• risedronate sodium oral tablet delayed

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	4 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Products Affected**

• risedronate sodium oral tablet 5 mg

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# risperiDONE

### **Products Affected**

• risperidone oral tablet 2 mg

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

# risperiDONE

### **Products Affected**

• risperidone oral tablet 4 mg

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

# **RisperiDONE**

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

# RisperiDONE

### **Products Affected**

• risperidone oral tablet 3 mg

• risperidone oral tablet dispersible 3 mg

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

# RisperiDONE

### **Products Affected**

• risperidone oral tablet dispersible 4 mg

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

# risperiDONE M-TAB

### **Products Affected**

• risperidone m-tab oral tablet dispersible 0.5 mg, 1 mg, 2 mg

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

# **RisperiDONE M-TAB**

### **Products Affected**

 risperidone m-tab oral tablet dispersible 3 mg

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

## **RisperiDONE M-TAB**

### **Products Affected**

 risperidone m-tab oral tablet dispersible 4 mg

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

# 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
<b>Covered Uses</b>	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

## Rizatriptan Benzoate

### **Products Affected**

• rizatriptan benzoate oral tablet

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

## Rizatriptan Benzoate

### **Products Affected**

• rizatriptan benzoate oral tablet dispersible

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

## 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: June 05, 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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **ROPINIRole HCl ER**

### **Products Affected**

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

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

### **Rosuvastatin Calcium**

### **Products Affected**

• rosuvastatin calcium

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastatin
QL Criteria	1 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Rubraca

### **Products Affected**

 RUBRACA ORAL TABLET 200 MG, 300 MG

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

### Sabril

### **Products Affected**

SABRIL ORAL TABLET

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

### 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

## Saizen Click. Easy

### **Products Affected**

• SAIZEN CLICK.EASY

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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: July 06, 2018

### Samsca

### **Products Affected**

SAMSCA ORAL TABLET 30 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 tabs 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 fill
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 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

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 25, 2015 Step Therapy: September 07, 2018 Quantity Limits: August 25, 2015

### Savella

### **Products Affected**

SAVELLA

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

### **Savella Titration Pack**

### **Products Affected**

### SAVELLA TITRATION PACK

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

### **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

### **Products Affected**

• SELZENTRY ORAL TABLET 150 MG

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

### **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

### **Products Affected**

SELZENTRY ORAL TABLET 75 MG

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

## Sensipar

## Products AffectedSENSIPAR

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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month.

12/01/2019

### **Serevent Diskus**

### **Products Affected**

SEREVENT DISKUS

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

### **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	
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

### **Sertraline HCl**

### **Products Affected**

• sertraline hcl oral tablet 100 mg

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

### **Sertraline HCl**

### **Products Affected**

• sertraline hcl oral tablet 25 mg

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

### **Sertraline HCl**

### **Products Affected**

• sertraline hcl oral tablet 50 mg

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

## **Signifor**

### **Products Affected**

SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/Sig nifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 amps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Siklos**

### **Products Affected**

### SIKLOS

PA Criteria	Criteria Details
<b>Covered Uses</b>	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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **Silenor**

### **Products Affected**

SILENOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of immediate release zolpidem or doxepin
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 09, 2018

## Simponi

#### **Products Affected**

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

### **Simvastatin**

#### **Products Affected**

• simvastatin oral tablet 10 mg, 5 mg, 80 mg

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

## Simvastatin

#### **Products Affected**

• simvastatin oral tablet 20 mg, 40 mg

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

### **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 tabs 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of linezolid
QL Criteria	6 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Smartest Blood Glucose Test**

#### **Products Affected**

SMARTEST BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Sodium Phenylbutyrate**

#### **Products Affected**

sodium phenylbutyrate oral powder 3 gm/tsp

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/meta bolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	20 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Sodium Phenylbutyrate**

#### **Products Affected**

• sodium phenylbutyrate oral tablet

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/meta bolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	40 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 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

## **Solus V2 Test**

#### **Products Affected**

### • SOLUS V2 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 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/San dostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 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

### 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 tab Per 1 Day
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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Incruse
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Spiriva Respimat

#### **Products Affected**

 SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Incruse
QL Criteria	1 inhaler Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Spiriva Respimat

#### **Products Affected**

 SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Incruse
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 tab 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, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 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/Stel ara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Stel ara.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 25, 2015

### 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/Stel ara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Stel ara.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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month.

12/01/2019

### 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/Stel ara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Stel ara.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	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/mis cendocrine.html
Exclusion Criteria	
Required Medical Information	
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

## **Stiolto Respimat**

#### **Products Affected**

 STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Anoro Ellipta
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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	4 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Stribild

#### **Products Affected**

• STRIBILD

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

# Striverdi Respimat

#### **Products Affected**

### STRIVERDI RESPIMAT

PA Criteria	Criteria Details
<b>Covered Uses</b>	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 Serevent
QL Criteria	1 inhaler Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Suboxone

#### **Products Affected**

SUBOXONE SUBLINGUAL FILM

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

## SulfaSALAzine

#### **Products Affected**

• sulfasalazine oral

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

## Sulfazine

### **Products Affected**

sulfazine

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

## **SUMAtriptan**

#### **Products Affected**

• sumatriptan nasal

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

## **SUMAtriptan Succinate**

#### **Products Affected**

• sumatriptan succinate subcutaneous solution 6 mg/0.5ml

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

## **SUMAtriptan Succinate**

#### **Products Affected**

• sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml

QL Criteria	10 carts/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 Refill**

#### **Products Affected**

• sumatriptan succinate refill subcutaneous solution cartridge

QL Criteria	10 carts/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

# **Sure Edge Test**

#### **Products Affected**

SURE EDGE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **SureChek Blood Glucose Test**

#### **Products Affected**

SURECHEK BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Sure-Test EasyPlus Mini Test**

#### **Products Affected**

SURE-TEST EASYPLUS MINI TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Sutent

#### **Products Affected**

• SUTENT ORAL CAPSULE 12.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 cap 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, 300 MCG, 600 MCG

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

## **Symbicort**

### **Products Affected**

#### SYMBICORT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Dulera or generic fluticasone/salmeterol (step therapy does not apply for COPD diagnosis, only asthma diagnosis)
QL Criteria	1 inhaler Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: March 08, 2019 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: August 25, 2015

## 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 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

<b>Revision Date</b>	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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## SymlinPen 60

#### **Products Affected**

 SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
<b>Covered Uses</b>	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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

## **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	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Synagis**

### **Products Affected**

SYNAGIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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

## **Synera**

### **Products Affected**

• SYNERA

QL Criteria	10 patches Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Synjardy**

#### **Products Affected**

SYNJARDY

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

# Synjardy XR

#### **Products Affected**

 SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG

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

# Synjardy XR

#### **Products Affected**

 SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG

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

## **Taclonex**

#### **Products Affected**

 TACLONEX EXTERNAL SUSPENSION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of calcipotriene and a medium to high potency topical steroid
QL Criteria	60 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Tacrolimus**

#### **Products Affected**

tacrolimus external

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid (triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, or fluticasone propionate ointment)
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Tadalafil**

#### **Products Affected**

• tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	Erectile dysfunction coverage is not covered unless Contract state of NY (see other criteria below) or members with ED rider benefit
Required Medical Information	A documented diagnosis of BPH (Benign Prostatic Hyperplasia), member is not currently on nitrite/nitrate therapy, is not currently on another phosphodiesterase-5 inhibitor, and has a documented contraindication, intolerance, allergy, or failure of a one month trial of one of the preferred drugs alfuzosin, finasteride, tamsulosin, Avodart, Jalyn or Rapaflo
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (daily dosing covered only for BPH diagnosis)
Other Criteria	For Fully Insured members of contract state New York: A documented primary diagnosis of erectile dysfunction in adult males over 18 years of age and a documented secondary diagnosis of one of the following: Diabetes, Hypertension, Spinal cord injury, Multiple sclerosis, Stroke, Radical surgery of genital tract, urinary tract, or rectum, or Hypogonadism, and member is not receiving any of the following organic nitrate product: Isosorbide mononitrate (Ismo), isosorbide dinitrate (Sorbitrate, Isordil, Dilatrate-SR), Nitroglycerin (NTG, Nitrostat, Nitro-Dur, Transderm-Nitro, Minitran, Nitro-par, Nitrol, Nitro-Bid, others) and member is not currently on another phosphodiesterase-5 inhibitor indicated for erectile dysfunction, and there is a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred alternative Cialis (For request of Levitra, Staxyn, Stendra, and Viagra)
QL Criteria	1 tablet Per 1 day

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

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/pulmon aryhypertensionagents.html
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 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Tanzeum**

#### **Products Affected**

### TANZEUM

PA Criteria	Criteria Details
<b>Covered Uses</b>	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 two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Tarceva

#### **Products Affected**

TARCEVA ORAL TABLET 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

# **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/T argretin.html
Exclusion Criteria	
Required Medical 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 caps 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: August 25, 2015

### **Tazarotene**

#### **Products Affected**

tazarotene external

ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **Tazorac**

#### **Products Affected**

ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Taztia XT

#### **Products Affected**

• taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg

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

## Taztia XT

#### **Products Affected**

• taztia xt oral capsule extended release 24 hour 240 mg

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

## **Tecfidera**

#### **Products Affected**

### TECFIDERA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/Tecfi dera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Tecfi dera.html
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

## **Technivie**

### **Products Affected**

### TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Techniv ie.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Techniv ie.html
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/MIS C/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**

#### **Products Affected**

TEKTURNA

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

## **Tekturna HCT**

#### **Products Affected**

### TEKTURNA HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two formulary angiotensin-converting enzyme inhibitors (ACE-I) or Angiotensin II receptor blockers (ARB) or generic aliskiren
QL Criteria	1 tab 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

### **Telcare Blood Glucose Test**

#### **Products Affected**

### • TELCARE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Telmisartan**

#### **Products Affected**

• telmisartan

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

# **Telmisartan-Amlodipine**

#### **Products Affected**

• telmisartan-amlodipine

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: candesartan, irbesartan, losartan, telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Telmisartan-HCTZ

#### **Products Affected**

• telmisartan-hctz

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

## **Temazepam**

#### **Products Affected**

• temazepam oral capsule 22.5 mg, 7.5 mg

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

# **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: 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: August 25, 2015

# **Testopel**

### **Products Affected**

#### TESTOPEL

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
Notes/ References	Annual Review: 07/2018

<b>Revision Date</b>	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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## **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	60 grams Per 1 fill

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

### **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%)

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

### **Testosterone**

#### **Products Affected**

 testosterone transdermal gel 25 mg/2.5gm (1%)

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

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

### **Testosterone**

#### **Products Affected**

• testosterone transdermal solution

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

2019 Aetna Small Group ACA: FL

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
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## **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/xena zine.html
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/xena zine.html
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

## **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/meta bolic_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/meta bolic_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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/meta bolic_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	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

## **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

# **Tivicay**

#### **Products Affected**

 TIVICAY ORAL TABLET 10 MG, 25 MG

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

# **Tivicay**

#### **Products Affected**

TIVICAY ORAL TABLET 50 MG

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

# **Tobramycin**

#### **Products Affected**

• tobramycin inhalation

QL Criteria	56 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Tolterodine Tartrate**

#### **Products Affected**

• tolterodine tartrate

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Tolterodine Tartrate ER**

#### **Products Affected**

• tolterodine tartrate er

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
QL Criteria	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Topiramate**

#### **Products Affected**

• topiramate oral capsule sprinkle

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

## **Toviaz**

### **Products Affected**

TOVIAZ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR and through either Vesicare or Myrbetriq
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Tradjenta

### **Products Affected**

TRADJENTA

QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### traMADol HCl

### **Products Affected**

tramadol hcl oral

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological 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 Small Group ACA: FL

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	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
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on 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 tramadol
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 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.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tramadol
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Tramadol-Acetaminophen

### **Products Affected**

• tramadol-acetaminophen

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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	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 tablet Per 1 fill
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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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

# **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/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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

## Tresiba

### **Products Affected**

TRESIBA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## Tresiba FlexTouch

### **Products Affected**

### • TRESIBA FLEXTOUCH

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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
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## **Triamcinolone Acetonide**

### **Products Affected**

triamcinolone acetonide nasal aerosol

ST Criteria	A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide
QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Trientine HCl**

### **Products Affected**

• trientine hcl

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

## **Trintellix**

### **Products Affected**

### TRINTELLIX

PA Criteria	Criteria Details
<b>Covered Uses</b>	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 (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 tablet Per 1 Day

Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 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/Gon adotropins.html
Exclusion Criteria	
Required Medical Information	
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 AffectedTRIUMEQ

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

# **Trospium Chloride ER**

### **Products Affected**

• trospium chloride er

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
QL Criteria	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **TRUEtest Test**

### **Products Affected**

### TRUETEST TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **TrueTrack Test**

### **Products Affected**

### TRUETRACK TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Trulicity**

### **Products Affected**

TRULICITY

PA Criteria	Criteria Details
<b>Covered Uses</b>	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 two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 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 Incruse
QL Criteria	1 inhaler Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **TussiCaps**

### **Products Affected**

TUSSICAPS

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

## **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 day max 20 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: April 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# **Tybost**

### **Products Affected**

TYBOST

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

# **Tykerb**

### **Products Affected**

TYKERB

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

# **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/bon e_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/bon e_disease_agents.html
QL Criteria	1 injection Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 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

## **Ultima Test**

#### **Products Affected**

### ULTIMA TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **UltraTRAK PRO Test**

#### **Products Affected**

### ULTRATRAK PRO TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### **UltraTRAK Ultimate Test**

#### **Products Affected**

### • ULTRATRAK ULTIMATE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 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 milliliters 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	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valsartan-Hydrochlorothiazide

#### **Products Affected**

• valsartan-hydrochlorothiazide

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

### Veltassa

#### **Products Affected**

### VELTASSA

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperkalemia
Exclusion Criteria	
Required Medical Information	Documentation that a member (at least 18 years of age) has a diagnosis of chronic kidney disease (CKD) and has hyperkalemia (serum potassium level of 5.1 to greater than 6.5 mEq/L), that the member is stable on an angiotensin converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), or an aldosterone antagonist (e.g. spironolactone, eplerenone)(if taking one of the medications), the patient has been counseled to take all other oral medications 3 hours before or 3 hours after Veltassa, Veltassa will not be used as an emergency treatment for life-threatening hyperkalemia, and the member is following a low potassium diet (less than or equal to 3 grams per day).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Reauthorization criteria: Use of Veltassa has been effective in treating hyperkalemia (e.g. current serum potassium level is lower than the pretreatment baseline serum potassium level), the member continues to require treatment for hyperkalemia, the member is stable on an angiotensin converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), or an aldosterone antagonist (e.g. spironolactone, eplerenone)(if taking one of the medications) and the member continues to follow a low potassium diet (less than or equal to 3 grams per day).
QL Criteria	1 packet Per 1 Day

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The formulary is updated the first week of each month. 12/01/2019

Notes/ References	
Revision Date	Prior Authorization: August 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 09, 2018

# Vemlidy

#### **Products Affected**

VEMLIDY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Vemlid y.html
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 09, 2018

#### **Products Affected**

• venlafaxine hcl oral tablet 100 mg, 25 mg

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

#### **Products Affected**

• venlafaxine hcl oral tablet 37.5 mg

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

#### **Products Affected**

• venlafaxine hcl oral tablet 50 mg

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

#### **Products Affected**

• venlafaxine hcl oral tablet 75 mg

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

#### **Products Affected**

• venlafaxine hcl er oral capsule extended release 24 hour 150 mg

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

#### **Products Affected**

• venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg

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

#### **Products Affected**

• venlafaxine hcl er oral tablet extended release 24 hour 150 mg

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

#### **Products Affected**

• venlafaxine hcl er oral tablet extended release 24 hour 225 mg, 37.5 mg, 75 mg

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

## Ventavis

#### **Products Affected**

VENTAVIS

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmon aryhypertensionagents.html
Exclusion Criteria	
Required Medical 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 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Verapamil HCl ER

#### **Products Affected**

• verapamil hcl er oral capsule extended release 24 hour 200 mg

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

## Verdeso

#### **Products Affected**

VERDESO

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

## Verdrocet

### **Products Affected**

VERDROCET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological 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

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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	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

#### **Products Affected**

• vicodin oral tablet 5-300 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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 Small Group ACA: FL

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	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 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

2019 Aetna Small Group ACA: FL

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	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

2019 Aetna Small Group ACA: FL

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

# **Victory AGM-4000 Test**

#### **Products Affected**

VICTORY AGM-4000 TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Victoza

#### **Products Affected**

 VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	9 ML Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 05, 2018 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	1 pak Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

## Viekira XR

#### **Products Affected**

#### VIEKIRA XR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	1 carton Per 28 Days
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: August 25, 2015

# Viibryd

#### **Products Affected**

VIIBRYD ORAL TABLET

QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viibryd Starter Pack

#### **Products Affected**

### VIIBRYD STARTER PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Vimpat

#### **Products Affected**

VIMPAT ORAL TABLET

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

### Viokace

# Products AffectedVIOKACE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep
Notes/ References	
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# Viramune XR

#### **Products Affected**

 VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG

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

# Viramune XR

#### **Products Affected**

 VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 400 MG

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

### Viread

#### **Products Affected**

VIREAD ORAL TABLET

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

# Vistogard

#### **Products Affected**

VISTOGARD

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

### **Vocal Point Blood Glucose Test**

#### **Products Affected**

 VOCAL POINT BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Voriconazole

#### **Products Affected**

voriconazole oral tablet

PA Criteria	Criteria Details
<b>Covered Uses</b>	Fungal infections
Exclusion Criteria	
Required Medical Information	Diagnosis of invasive aspergillosis or with a serious systemic fungal infection caused by Scedosporium apiospermum and Fusarium spp., for the treatment of esophageal candidiasis that is resistant to treatment with fluconazole and itraconazole, or for the treatment of candidemia in non-neutropenic patients and the following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds that are unresponsive to treatment with fluconazole (Continue therapy for 14 days after the patient is afebrile and blood cultures are negative).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Invasive aspergillosis: 12 weeks, Oral Candidiasis: 3 weeks MAX, Candidemia: 12 weeks
Other Criteria	
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 13, 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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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

<b>Revision Date</b>	Prior Authorization: August 22, 2018 Step Therapy: September 07, 2018 Quantity Limits: August 25, 2015
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## 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

<b>Revision Date</b>	Prior Authorization: August 22, 2018 Step Therapy: September 07, 2018 Quantity Limits: August 25, 2015
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## 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

2019 Aetna Small Group ACA: FL

The formulary is updated the first week of each month. 12/01/2019

<b>Revision Date</b>	Prior Authorization: August 22, 2018 Step Therapy: September 07, 2018 Quantity Limits: August 25, 2015
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## 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

<b>Revision Date</b>	Prior Authorization: August 22, 2018 Step Therapy: September 07, 2018 Quantity Limits: August 25, 2015
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## Vyvanse

#### **Products Affected**

### VYVANSE ORAL CAPSULE

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Binge Eating Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) or Binge Eating Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD or Binge Eating Disorder AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### Vyvanse

#### **Products Affected**

 VYVANSE ORAL TABLET CHEWABLE

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Binge Eating Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) or Binge Eating Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD or Binge Eating Disorder AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

### **WaveSense Presto**

#### **Products Affected**

#### WAVESENSE PRESTO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

#### **Products Affected**

• WIDE-SEAL DIAPHRAGM 60

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

#### **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: June 05, 2019

#### **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

#### **Products Affected**

WIDE-SEAL DIAPHRAGM 75

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

#### **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

#### **Products Affected**

• WIDE-SEAL DIAPHRAGM 85

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

#### **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

#### **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

### Wilate

#### **Products Affected**

WILATE INTRAVENOUS KIT

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

### 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

### 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 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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 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/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: August 25, 2015

## Xeljanz

#### **Products Affected**

XELJANZ ORAL TABLET 5 MG

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

# Xeljanz XR

#### **Products Affected**

XELJANZ XR

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

## 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/bon e_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/bon e_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

### **Xiaflex**

#### **Products Affected**

· XIAFLEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/dup uytrens_contracture_treatments.html
Exclusion Criteria	
Required Medical Information	
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

## Xifaxan

#### **Products Affected**

XIFAXAN ORAL TABLET 200 MG

QL Criteria	9 tabs Per 1 fill
Notes/ References	Annual Review: 04/2017
<b>Revision Date</b>	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 10-1000 MG, 10-500 MG, 5-500 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

## Xigduo XR

#### **Products Affected**

 XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 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

## 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

# Xolegel

### **Products Affected**

XOLEGEL

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

# **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	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 (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	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 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	16 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

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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	

### 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 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: March 01, 2019 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/meta bolic_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

## **Xylon**

#### **Products Affected**

• XYLON

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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

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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	5 tablets Per 1 Day	
Notes/ References		
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015	

# **Xyrem**

#### **Products Affected**

XYREM

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

### Zafirlukast

### **Products Affected**

zafirlukast

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

# Zaleplon

### **Products Affected**

• zaleplon

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

### 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/gau cher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/gau cher_disease.html
QL Criteria	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

# Zegerid

#### **Products Affected**

 ZEGERID ORAL CAPSULE 40-1100 MG

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

# **Zegerid OTC**

#### **Products Affected**

ZEGERID OTC

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

## 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/Ze jula.html
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 09, 2018

## Zelapar

### **Products Affected**

ZELAPAR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of selegiline
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

### Zenatane

#### **Products Affected**

### ZENATANE

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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 05, 2018 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/Zepatie r.html
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

## Zetonna

### **Products Affected**

### ZETONNA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Zileuton ER**

#### **Products Affected**

• zileuton er

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

# Zioptan

#### **Products Affected**

### · ZIOPTAN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Ziprasidone HCl**

#### **Products Affected**

• ziprasidone hcl

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

## 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 caps 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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 tablets Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Zolpidem Tartrate**

#### **Products Affected**

• zolpidem tartrate oral

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

# **Zolpidem Tartrate ER**

#### **Products Affected**

• zolpidem tartrate er

PA Criteria	Criteria Details
<b>Covered Uses</b>	Insomnia
Exclusion Criteria	
Required Medical Information	A diagnosis of insomnia
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 zolpidem tartrate or zalelpon
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

## **Zomacton**

### **Products Affected**

### ZOMACTON

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

# **Zomig**

#### **Products Affected**

### · ZOMIG NASAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 sprays Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 05, 2018 Quantity Limits: August 25, 2015

# **Zontivity**

#### **Products Affected**

### ZONTIVITY

PA Criteria	Criteria Details
Covered Uses	Reduction of the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD)
Exclusion Criteria	Do not use in patients with history of stroke, history of transient ischemic attack (TIA), or history of intracranial hemorrhage (ICH), or active pathological bleeding
Required Medical Information	Documented diagnosis or history of myocardial infarction (MI) or peripheral arterial disease (PAD) and concurrent use of aspirin or clopidogrel.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## **Z**orbtive

#### **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	
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

# **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 tablets Per 1 Day
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 CAPSULE

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	5 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 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

# 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

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<i>vicodin oral tablet 5-300 mg</i> 1321	WIDE-SEAL DIAPHRAGM 751360
VICTORY AGM-4000 TEST1327	WIDE-SEAL DIAPHRAGM 801361
VICTOZA SUBCUTANEOUS	WIDE-SEAL DIAPHRAGM 851362
SOLUTION PEN-INJECTOR1328	WIDE-SEAL DIAPHRAGM 901363
VIEKIRA PAK	WIDE-SEAL DIAPHRAGM 951364
VIEKIRA XR1330	WILATE INTRAVENOUS KIT 1365
vigabatrin oral packet1331	WIXELA INHUB 1366
vigabatrin oral tablet1332	XALKORI1367
VIGADRONE1333	XATMEP
VIIBRYD ORAL TABLET 1334	XELJANZ ORAL TABLET 10 MG 1369
VIIBRYD STARTER PACK1335	XELJANZ ORAL TABLET 5 MG 1370
VIMPAT ORAL TABLET1336	XELJANZ XR1371
VIOKACE1337	XELPROS
VIRAMUNE XR ORAL TABLET	XGEVA1373
EXTENDED RELEASE 24 HOUR 100	XIAFLEX1374
MG	XIFAXAN ORAL TABLET 200 MG.1375
VIRAMUNE XR ORAL TABLET	XIFAXAN ORAL TABLET 550 MG.1376
EXTENDED RELEASE 24 HOUR 400	XIGDUO XR ORAL TABLET
MG1339	EXTENDED RELEASE 24 HOUR 10-
VIREAD ORAL TABLET1340	1000 MG, 10-500 MG, 5-500 MG1377
VISTOGARD1341	XIGDUO XR ORAL TABLET
VOCAL POINT BLOOD GLUCOSE	EXTENDED RELEASE 24 HOUR 2.5-
TEST1342	1000 MG, 5-1000 MG1378
voriconazole oral tablet1343	XOFLUZA1379
VOSEVI	XOLEGEL
VOTRIENT1345	XPOVIO (100 MG ONCE WEEKLY) 1381
	XPOVIO (60 MG ONCE WEEKLY)1382
	XPOVIO (80 MG ONCE WEEKLY)1383

XPOVIO (80 MG TWICE WEEKLY	)1384
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XTANDI	1387
XURIDEN	1388
XYLON	
XYREM	1391
zafirlukast	1392
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ZAVESCA	
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ZEGERID OTC	1397
ZEJULA	1398
ZELAPAR	1399
ZELBORAF	1400
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ZENZEDI ORAL TABLET 10 MG,	5
MG	1402
ZEPATIER	1403
ZETONNA	1404
zileuton er	1405
ZIOPTAN	1406
ziprasidone hcl	1407
ZOLINZA	. 1408
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ZOMIG NASAL	
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ZYDELIG	1416
ZYFLO	1417
ZYKADIA ORAL CAPSULE	
ZYKADIA ORAL TABLET	
ZVTIGA ORAL TARLET 500 MG	