2019 Aetna Small Group ACA

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
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

Accu-Chek Compact Plus

Products Affected
- ACCU-CHEK COMPACT PLUS

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

Accu-Chek SmartView

Products Affected
- ACCU-CHEK SMARTVIEW

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

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
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

Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral solution*

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

PA Criteria	Criteria Details
Other Criteria	Other Criteria: A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
QL Criteria	150 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acetaminophen-Codeine

Products Affected

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

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

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	Other Criteria: A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
QL Criteria	13 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acetaminophen-Codeine

Products Affected

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

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

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	Other Criteria: A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
QL Criteria	10 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acetaminophen-Codeine #2

Products Affected

- *acetaminophen-codeine #2*

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

2019 Aetna Small Group ACA
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

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
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/Actemra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Actemra.html
QL Criteria	1 syringe 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
The formulary is updated the first week of each month.
12/01/2019

Actemra ACTPen

Products Affected
- ACTEMRA ACTPEN

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

Actimmune

Products Affected
- ACTIMMUNE

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

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 04, 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 04, 2018 Quantity Limits: August 25, 2015

Adapalene

Products Affected
- *adapalene external solution*

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

Adcirca

Products Affected
- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
QL Criteria	2 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
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/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
QL Criteria	3 tabs Per 1 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
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 Test

Products Affected
- ADVOCATE 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

Aemcolo

Products Affected
- AEMCOLO

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

Afeditab CR

Products Affected

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

QL Criteria	1 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
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 KeyNote Test

Products Affected
- AGAMATRIX KEYNOTE 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 Presto Test

Products Affected
- AGAMATRIX PRESTO 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

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	

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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 04, 2018 Quantity Limits: August 25, 2015

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 10 mg*

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

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 35 mg*

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

Alendronate Sodium

Products Affected

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

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

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 70 mg*

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

Alfuzosin HCl ER

Products Affected
- *alfuzosin hcl er*

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

Alinia

Products Affected

- ALINIA ORAL SUSPENSION RECONSTITUTED

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

Alinia

Products Affected
- ALINIA ORAL TABLET

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

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 04, 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 04, 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 04, 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 04, 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/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 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 04, 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
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 04, 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
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 04, 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

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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	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 04, 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 04, 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

Aptiom

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

Aptiom

Products Affected

- APTIOM ORAL TABLET 400 MG, 800 MG

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

Aptiom

Products Affected

- APTIOM ORAL TABLET 600 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

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

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Arcalyst

Products Affected
- ARCALYST

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

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 04, 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

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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

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 04, 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 04, 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 04, 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 04, 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 04, 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 04, 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
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 Platinum

Products Affected
- ASSURE PLATINUM

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 Pro Test

Products Affected
- ASSURE PRO 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

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: December 18, 2017

Atomoxetine HCl

Products Affected

- *atomoxetine hcl oral capsule 100 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

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: August 25, 2015

Atomoxetine HCl

Products Affected

- *atomoxetine hcl oral capsule 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: December 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/Aubagio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Aubagio.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

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

Avonex

Products Affected
- AVONEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
QL Criteria	1 kit Per 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/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
QL Criteria	4 pens Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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Avonex Prefilled

Products Affected

- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

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

Bayer Contour Test

Products Affected
- BAYER CONTOUR 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

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 04, 2018 Quantity Limits: August 25, 2015

Belsomra

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	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 04, 2018 Quantity Limits: August 25, 2015

Belviq

Products Affected
- BELVIQ

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 04, 2018 Quantity Limits: August 25, 2015

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Benlysta

Products Affected
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/benlysta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/benlysta.html
QL Criteria	4 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Benzhydrocodone-Acetaminophen

Products Affected

- *benzhydrocodone-acetaminophen*

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

2019 Aetna Small Group ACA
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 04, 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/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Bexarotene

Products Affected
- *bexarotene*

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

Bicalutamide

Products Affected
- *bicalutamide*

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

Biktarvy

Products Affected
- BIKTARVY

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

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 04, 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/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bosulif

Products Affected
- BOSULIF 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

Bravelle

Products Affected
- BRAVELLE

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

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
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	60 vials Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 04, 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 04, 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

Buprenorphine

Products Affected
- *buprenorphine transdermal*

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

2019 Aetna Small Group ACA
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 11, 2018

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl sublingual tablet sublingual*

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

buPROPion HCl

Products Affected

- *bupropion hcl oral*

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

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

QL Criteria	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

2019 Aetna Small Group ACA
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

PA Criteria	Criteria Details
Other Criteria	Other Criteria: A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
QL Criteria	6 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Butorphanol Tartrate

Products Affected
- *butorphanol tartrate nasal*

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

PA Criteria	Criteria Details
Other Criteria	Other Criteria: A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
QL Criteria	2 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 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 04, 2018 Quantity Limits: August 25, 2015

Bydureon BCise

Products Affected
- BYDUREON BCISE

PA Criteria	Criteria Details
Covered Uses	Type 2 diabetes mellitus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
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 04, 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 04, 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 04, 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/cablivi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 vial per day, 2 courses (58 day supply) Per 1 lifetime
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 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 04, 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 04, 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

Candesartan Cilexetil

Products Affected

- *candesartan cilexetil oral tablet 16 mg, 4 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

Candesartan Cilexetil

Products Affected

- *candesartan cilexetil oral tablet 32 mg*

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

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz*

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

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
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

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 04, 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 04, 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/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 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: September 06, 2019

Cetrotide

Products Affected

- CETROTIDE SUBCUTANEOUS KIT
  0.25 MG

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

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 Affected
- CHENODAL

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

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

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/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

Ciclodan

Products Affected
- *ciclodan external solution*

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

Ciclopirox

Products Affected
- *ciclopirox external solution*

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

Cimduo

Products Affected
- CIMDUO

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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 04, 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
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 Test

Products Affected
- CLEVER CHEK 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 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
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

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

Clobetasol Propionate

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

Clobetasol Propionate

Products Affected

- *clobetasol propionate external foam*

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

Clobetasol Propionate

Products Affected

- *clobetasol propionate external liquid*

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

Clobetasol Propionate

Products Affected

- *clobetasol propionate external lotion*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	236 ml Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

Clobetasol Propionate

Products Affected

- *clobetasol propionate external shampoo*

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

Clobetasol Propionate

Products Affected

- *clobetasol propionate external solution*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	100 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

Clobetasol Propionate E

Products Affected

- *clobetasol propionate e*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	120 grams Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 04, 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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 200 mg*

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

Codeine Sulfate

Products Affected

- *codeine sulfate oral tablet 15 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological 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
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
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
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: August 25, 2015

CombiPatch

Products Affected
- COMBIPATCH

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

Combivent Respimat

Products Affected
- COMBIVENT RESPIMAT

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

Cometriq (100 mg Daily Dose)

Products Affected
- COMETRIQ (100 MG DAILY DOSE)

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

Corlanor

Products Affected
- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	FDA labeled use for heart failure
Exclusion Criteria	
Required Medical Information	Documentation of stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater or equal to 70 beats per minute and who are on maximally tolerated doses of beta-blockers (such as bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate, metoprolol succinate-HCTZ, or nevibolol) or have a documented contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one 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 04, 2018 Quantity Limits: August 25, 2015

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 04, 2018 Quantity Limits: August 08, 2018

Cortifoam

Products Affected
- CORTIFOAM

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

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 04, 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 04, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

Cystagon

Products Affected
- CYSTAGON

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

Cystaran

Products Affected
- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 bottles Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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/Daklinza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Daklinza.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
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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 04, 2018 Quantity Limits: August 25, 2015

Daytrana

Products Affected
- DAYTRANA

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of ADHD and there is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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 04, 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/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Delstrigo

Products Affected
- DELSTRIGO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
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 04, 2018 Quantity Limits: August 25, 2015

Depen Titratabs

Products Affected
- DEPEN TITRATABS

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

Descovy

Products Affected
- DESCOVY

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

Desloratadine

Products Affected

- *desloratadine oral tablet*
- *desloratadine oral tablet dispersible 2.5 mg*

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 04, 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

Desoximetasone

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of betamethasone dipropionate (cream/ointment/lotion)
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

Desvenlafaxine Succinate ER

Products Affected
- *desvenlafaxine succinate er*

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin for details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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
The formulary is updated the first week of each month.
12/01/2019

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 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 04, 2018 Quantity Limits: August 25, 2015

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

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

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

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

Diacomit

Products Affected
- DIACOMIT ORAL CAPSULE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/diacomit.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diacomit

Products Affected
- DIACOMIT ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/diacomit.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

DilTIAZem CD

Products Affected

- *diltiazem cd oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg*

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

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 HCl ER

Products Affected

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

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

Diltiazem HCl ER Beads

Products Affected

- *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 300 mg, 360 mg*

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Coated Beads

Products Affected

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

QL Criteria	2 tablets 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 04, 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
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

Donepezil HCl

Products Affected
- *donepezil hcl oral tablet 23 mg*

PA Criteria	Criteria Details
Covered Uses	Alzheimers Disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild, moderate, or severe Alzheimers Disease
Age Restrictions	PA applies to members less than 40 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
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 04, 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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dronabinol

Products Affected
- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
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 04, 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 04, 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 04, 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
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 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
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

EasyMax 15 Test

Products Affected
- EASYMAX 15 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

EASYMax Test

Products Affected
- EASYMAX 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

EasyPlus Blood Glucose Test

Products Affected
- EASYPLUS 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

EasyPRO Plus

Products Affected
- EASYPRO PLUS 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

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 04, 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 04, 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 04, 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/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eliquis

Products Affected
- ELIQUIS

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 04, 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 04, 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	

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

Embeda

Products Affected

- EMBEDA ORAL CAPSULE EXTENDED RELEASE 20-0.8 MG, 30-1.2 MG

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

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The formulary is updated the first week of each month.
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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/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Enbrel.html
QL Criteria	8 syringes Per 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
The formulary is updated the first week of each month.
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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
The formulary is updated the first week of each month.
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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

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

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

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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 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

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The formulary is updated the first week of each month.
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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	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
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 07, 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/epidiolex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/epidiolex.html
QL Criteria	20 ml Per 1 day
Notes/ References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: November 10, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

Epoprostenol Sodium

Products Affected

- *epoprostenol sodium*

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

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

QL Criteria	1 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/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	9 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 07, 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/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	9 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Esbriet

Products Affected
- ESBRIET ORAL TABLET 801 MG

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

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

Escitalopram Oxalate

Products Affected

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

QL Criteria	1 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/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin for details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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	

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

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

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
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

EvenCare Blood Glucose Test

Products Affected
- EVENCARE 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

EvenCare G2 Test

Products Affected
- EVENCARE G2 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

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
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

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 04, 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 08, 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/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Extavia

Products Affected
- EXTAVIA SUBCUTANEOUS KIT

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

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

Eylea

Products Affected
- EYLEA INTRAVITREAL

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

Ez Smart Blood Glucose Test

Products Affected
- EZ SMART 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

Ez Smart Plus Glucose Test

Products Affected
- EZ SMART PLUS 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

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 04, 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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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
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

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

FentaNYL Citrate

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

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

PA Criteria	Criteria Details
Other Criteria	For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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 04, 2018 Quantity Limits: August 25, 2015

Ferriprox

Products Affected
- FERRIPROX

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

Fetzima

Products Affected
- FETZIMA

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 04, 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 04, 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 04, 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

Fifty50 Glucose Test 2.0

Products Affected
- FIFTY50 GLUCOSE TEST 2.0

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

Firdapse

Products Affected
- FIRDAPSE

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

Firmagon

Products Affected
- FIRMAGON

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

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 04, 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 04, 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 04, 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 04, 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 04, 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 04, 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 07, 2018

FLUoxetine HCl

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

FLUoxetine HCl

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

FLUoxetine HCl

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 60 mg*

QL Criteria	1 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 04, 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 mcg/act, 232-14 mcg/act, 55-14 mcg/act*

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

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

Follistim AQ

Products Affected
- FOLLISTIM AQ SUBCUTANEOUS

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

FORA D20 Blood Glucose Test

Products Affected
- FORA D20 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

FORA G20 Blood Glucose Test

Products Affected
- FORA G20 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

FORA G30/Prem V10 Glucose Test

Products Affected

- FORA G30/PREM V10 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

Fora GD20 Test

Products Affected
- FORA GD20 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

FORA V10 Blood Glucose Test

Products Affected
- FORA V10 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

FORA V12 Blood Glucose Test

Products Affected
- FORA V12 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

FORA V20 Blood Glucose Test

Products Affected
- FORA V20 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

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
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 premium V10 Test

Products Affected
- FORACARE PREMIUM V10 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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Forteo

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML

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

Fosamax 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 04, 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 04, 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

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gabapentin

Products Affected
- *gabapentin oral solution*

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

Gabapentin

Products Affected

- *gabapentin oral tablet*

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

Galafold

Products Affected
- GALAFOLD

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

Galantamine Hydrobromide

Products Affected
- *galantamine hydrobromide*

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

Galantamine Hydrobromide ER

Products Affected
- *galantamine hydrobromide er*

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

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

Ganirelix Acetate

Products Affected
- *ganirelix acetate subcutaneous solution*

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

Gattex

Products Affected
- GATTEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Gattex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 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 Affected

- GELNIQUE TRANSDERMAL GEL 10 %

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 04, 2018 Quantity Limits: August 25, 2015

Gelnique Pump

Products Affected
- GELNIQUE 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 04, 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 Affected
- GENOTROPIN 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

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	
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

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 04, 2018 Quantity Limits: August 25, 2015

Gilenya

Products Affected
- GILENYA

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

Glucocard Expression Test

Products Affected

- GLUCOCARD EXPRESSION 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

Glucocard Vital Test

Products Affected
- GLUCOCARD VITAL 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

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
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

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 04, 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/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

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 04, 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 04, 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

GuanFACINE HCl 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/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/hereditary_angioedema.html
QL Criteria	16 kits Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 07, 2018

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Hemangeol

Products Affected
- HEMANGEOL

PA Criteria	Criteria Details
Covered Uses	Proliferating infantile hemangioma
Exclusion Criteria	History of asthma or bronchospasms
Required Medical Information	A documented diagnosis of proliferating infantile hemangioma requiring systemic therapy and documented all of the following: (1) Member was not born prematurely with a corrected age of less than 5 weeks, (2) Member does not weigh less than 2kg, have sustained heart rate less than 80 beats per minute, have greater than first degree heart block, or have decompensated heart failure, and (3) Member does not have sustained blood pressure less than 50/ 30mmHg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 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 04, 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

Humira

Products Affected

- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Humira

Products Affected

- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Humira.html
QL Criteria	2 injections 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
The formulary is updated the first week of each month.
12/01/2019

Humira

Products Affected

- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Humira.html
QL Criteria	6 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Humira

Products Affected

- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Humira.html
QL Criteria	6 injections 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
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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
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

2019 Aetna Small Group ACA
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 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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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	

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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	

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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	

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

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

HYDROmorphone HCl

Products Affected

- *hydromorphone hcl oral tablet 4 mg*

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

2019 Aetna Small Group ACA
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

HYDROmorphone HCl

Products Affected

- *hydromorphone hcl oral tablet 8 mg*

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

2019 Aetna Small Group ACA
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 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
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

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
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	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
- HYSINGLA ER

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

2019 Aetna Small Group ACA
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	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
Covered Uses	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 04, 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
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

Icatibant Acetate

Products Affected
- *icatibant acetate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: 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/Ilaris.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

Increlex

Products Affected
- INCRELEX

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

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 07, 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 07, 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
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	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 04, 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

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

Jynarque

Products Affected

- JYNARQUE ORAL TABLET
  THERAPY PACK

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

Kadian

Products Affected

- KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 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	

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The formulary is updated the first week of each month.
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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 04, 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 04, 2018 Quantity Limits: August 25, 2015

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The formulary is updated the first week of each month.
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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/Kineret.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Kineret.html
QL Criteria	1 syringe Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
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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 INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 3000 UNIT

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

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 04, 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 04, 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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lactulose

Products Affected
- *lactulose oral packet*

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

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 04, 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 04, 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/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Leuprolide Acetate

Products Affected
- *leuprolide acetate injection*

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

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 04, 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

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The formulary is updated the first week of each month.
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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	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

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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	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
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

Liberty Test

Products Affected
- LIBERTY 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

Lidocaine

Products Affected
- *lidocaine external ointment*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, sensitivity to amide-type local anesthetics or any other component of the product, planned use on large surface area of the body as this can lead to increased toxicity, planned area of application includes severely traumatized skin (e.g.,mucosal or skin abrasion, eczema, burns), the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), of if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for temporary anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months

PA Criteria	Criteria Details
Other Criteria	*Topical lidocaine ointment is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Approval can made up to an additional 50gms per 30 days. Higher additional quantities are not approvable *FOR ADULTS: A single application should not exceed 5 g of Lidocaine Ointment 5%, containing 250 mg of lidocaine base (equivalent chemically to approximately 300 mg of lidocaine hydrochloride). This is roughly equivalent to squeezing a six (6) inch length of ointment from the tube. In a 70 kg adult this dose equals 3.6 mg/kg (1.6 mg/lb) lidocaine base. No more than one-half tube, approximately 17-20 g of ointment or 850-1000 mg lidocaine base, should be administered in any one day. FOR CHILDREN: For children less than ten years who have a normal lean body mass and a normal lean body development, the maximum dose may be determined by the application of one of the standard pediatric drug formulas (e.g., Clark's rule). For example a child of five years weighing 50 lbs., the dose of lidocaine should not exceed 75-100 mg when calculated according to Clark's rule. In any case, the maximum amount of lidocaine administered should not exceed 4.5 mg/kg (2.0 mg/lb) of body weight ***Lidocaine toxicity resulting from transcutaneous absorption is theoretically possible. Signs and symptoms of systemic lidocaine toxicity include CNS excitation and/or depression, nervousness, confusion, dizziness, tinnitus, blurred or double vision, vomiting, twitching, tremors, seizures, unconsciousness, respiratory depression, bradycardia, hypotension, and cardiopulmonary arrest. If there is suspicion of lidocaine-related systemic toxicity, check lidocaine blood concentrations
QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: October 03, 2016 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*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 30 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 30 grams every 30 days, there must be a documented temporary need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, Sensitivity to amide-type local anesthetics or any other component of the product, Planned use on large surface area of the body or for a period of time over 3 hours as this can lead to increased toxicity, the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), Use in situations where the drug may migrate into the middle ear, beyond the tympanic membrane, History of methemoglobinemia, or if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months

PA Criteria	Criteria Details
Other Criteria	*Topical lidocaine/prilocaine cream is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity.Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Up to an additional 30 grams per 30 days. Higher additional quantities are not approvable.
QL Criteria	30 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: October 05, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Linezolid

Products Affected
- *linezolid oral suspension reconstituted*

QL Criteria	150 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Linezolid

Products Affected
- *linezolid oral tablet*

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

Linzess

Products Affected

- LINZESS ORAL CAPSULE 145 MCG, 290 MCG

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 04, 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 04, 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 04, 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
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
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	

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION 0.01 %

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

Lupron Depot (1-Month)

Products Affected
- LUPRON DEPOT (1-MONTH)

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Lupron Depot (3-Month)

Products Affected
- LUPRON DEPOT (3-MONTH)

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

Lupron Depot (4-Month)

Products Affected
- LUPRON DEPOT (4-MONTH)

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

Lupron Depot (6-Month)

Products Affected
- LUPRON DEPOT (6-MONTH)

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

Lupron Depot-Ped (1-Month)

Products Affected
- LUPRON DEPOT-PED (1-MONTH)

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

Lupron Depot-Ped (3-Month)

Products Affected
- LUPRON DEPOT-PED (3-MONTH)

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

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/hydroxyprogesterone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	21 syringes Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: September 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/Mavyret.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Mavyret.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

Menopur

Products Affected
- MENOPUR

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

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

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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	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

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

Mephyton

Products Affected
- MEPHYTON

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

Mesalamine

Products Affected

- *mesalamine oral capsule delayed release*

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

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 1.2 gm*

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

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 800 mg*

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

Mesalamine

Products Affected

- *mesalamine rectal suppository*

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

Metadate ER

Products Affected

- *metadate er oral tablet extended release 20 mg*

QL Criteria	3 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 04, 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 04, 2018 Quantity Limits: August 25, 2015

Methadone HCl

Products Affected
- *methadone hcl oral concentrate*

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

PA Criteria	Criteria Details
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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

Methadone HCl

Products Affected
- *methadone hcl oral solution 10 mg/5ml*

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

PA Criteria	Criteria Details
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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

Methadone HCl

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

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

PA Criteria	Criteria Details
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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

Methadone HCl

Products Affected

- *methadone hcl oral tablet 10 mg*

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

PA Criteria	Criteria Details
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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The formulary is updated the first week of each month.
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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	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 30, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadone HCl

Products Affected
- *methadone hcl oral tablet 5 mg*

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

PA Criteria	Criteria Details
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

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

Methadone HCl Intensol

Products Affected
- *methadone hcl intensol*

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

PA Criteria	Criteria Details
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

2019 Aetna Small Group ACA
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	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
Covered Uses	All FDA approved indications
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on an opioid wean at time of hospital discharge, the continuation of medication will be approved for up to 1 month. 4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) & the patient will be monitored during therapy for signs & symptoms of abuse/misuse, compliance & the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy- see required medical information

PA Criteria	Criteria Details
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
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 04, 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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet chewable*

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 10 mg*

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 18 mg, 27 mg, 54 mg*

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 20 mg*

QL Criteria	3 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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 36 mg*

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 72 mg*

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg*

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 24 hour 36 mg*

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

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

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

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 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/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/gaucher_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/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mirtazapine

Products Affected
- *mirtazapine oral 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 04, 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 04, 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 04, 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*

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

Montelukast Sodium

Products Affected

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	Other Criteria: A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
QL Criteria	6 suppositories Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate

Products Affected

- *morphine sulfate rectal suppository 20 mg*

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

2019 Aetna Small Group ACA
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

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The formulary is updated the first week of each month.
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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	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	

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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	

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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 04, 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
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological & non-pharmacological agents for pain relief as appropriate, addiction risk assessment has been performed, a signed informed consent has been obtained, & a written/signed agreement between prescriber & patient addressing issues of prescription management, diversion, & the use of other substances exists. When these criteria are met, the medication will be approved for 3 months. Continuation requests may be approved for up to an additional 6 months. 3) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN: An initial prescription of up to a 7 day supply for acute pain is covered without prior authorization. For coverage beyond 7 days the following criteria apply: For instances including post-surgical pain, large surgical procedures, short term treatment of a traumatic injury, or for a child on 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 04, 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	

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

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral tablet extended release 15 mg, 30 mg*

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

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

Morphine Sulfate ER Beads

Products Affected

- *morphine sulfate er beads*

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

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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.
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 04, 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/Mozobil.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mulpleta

Products Affected
- MULPLETA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/thrombopoietin_receptor_agonists.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 /day for 7 days Per 30 days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Multaq

Products Affected
- MULTAQ

QL Criteria	2 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/Myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	15 vials Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

MyGlucoHealth Test

Products Affected
- MYGLUCOHEALTH 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

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 04, 2018 Quantity Limits: August 25, 2015

Myrbetriq

Products Affected
- MYRBETRIQ

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 04, 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 04, 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 04, 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 04, 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 04, 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	
Revision Date	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 04, 2018 Quantity Limits: August 25, 2015

Neutek 2Tek Test

Products Affected
- NEUTEK 2TEK 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

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

Revision Date	Prior Authorization: August 13, 2018 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

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

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: October 18, 2017

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

Nivestym

Products Affected
- NIVESTYM

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

Nocdurna

Products Affected
- NOCDURNA

PA Criteria	Criteria Details
Covered Uses	Initial Criteria Treatment of nocturia in adult patients with a documented diagnosis of nocturnal polyuria that meet all of the following: 1. Diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection where night-time urine production exceeds one-third of the 24-hour urine production, AND 2. Patient awakens at least 2 times per night to void, AND 3. Other causes of nocturia, such as excessive fluid intake prior to bedtime, have been ruled out, AND 4. Patient does not have an increased risk of severe hyponatremia, such as patients with a history of hyponatremia, excessive fluid intake, polydipsia, illnesses that can cause fluid or electrolyte imbalances (such as gastroenteritis, salt-wasting nephropathies, or systemic infection), renal impairment with estimated glomerular filtration rate (eGFR) below 50 mL/min/1.73 m2, known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion, and in those using loop diuretics or systemic or inhaled glucocorticoids, AND 5. Patient does not have heart failure, AND 6. Patient does not have uncontrolled hypertension, AND 7. Patient is not pregnant, AND 8. Serum sodium concentration is normal before starting or resuming Nocdurna, AND 9. Serum sodium concentration will be within 1 week and approximately 1 month of initiating Nocdurna, and periodically thereafter. Continuation Criteria Nocdurna will be continued for 3 month intervals for patients with a documented diagnosis of nocturnal polyuria that meet all of the following;

PA Criteria	Criteria Details
	1. Serum sodium concentration was normal within 1 week after starting Nocdurna and again at 1 month after starting Nocdurna, AND 2. Patient has had a decrease in voiding episodes at night, AND 3. Patient does not have an increased risk of severe hyponatremia, such as patients with a history of hyponatremia, excessive fluid intake, polydipsia, illnesses that can cause fluid or electrolyte imbalances (such as gastroenteritis, salt-wasting nephropathies, or systemic infection), renal impairment with estimated glomerular filtration rate (eGFR) below 50 mL/min/1.73 m2, known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion, and in those using loop diuretics or systemic or inhaled glucocorticoids, AND 4. Patient does not have heart failure, AND 5. Patient does not have uncontrolled hypertension, AND 6. Patient is not pregnant, AND 7. Serum sodium concentration will be monitored periodically based on the patient's risk for hyponatremia but will be monitored more frequently for patients age 65 and older, and for patients on concomitant medications that can increase the risk of hyponatremia, such as tricyclic antidepressants, selective serotonin reuptake inhibitors, nonsteroidal anti-inflammatory drugs (NSAIDs), chlorpromazine, opiate analgesics, carbamazepine, lamotrigine, thiazide diuretics and chlorpropamide.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month (initial authorization), 3 month (reauthorization)
Other Criteria	
QL Criteria	1 tablet Per 1 Day

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

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
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

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/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

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 04, 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 04, 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 04, 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 04, 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 04, 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 04, 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/nplate.html
Exclusion Criteria	
Required Medical Information	
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
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 04, 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
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 04, 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
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 04, 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
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/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

OLANZapine

Products Affected

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

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

OLANZapine

Products Affected

- *olanzapine oral tablet 15 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 05, 2019

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

Products Affected

- *olanzapine oral tablet dispersible 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: November 12, 2019

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

Olumiant

Products Affected
- OLUMIANT ORAL TABLET 2 MG

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

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The formulary is updated the first week of each month.
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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 04, 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
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

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 04, 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	

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The formulary is updated the first week of each month.
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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 04, 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/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 2018 Quantity Limits: August 25, 2015

Orencia

Products Affected

- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Orencia.html
QL Criteria	4 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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The formulary is updated the first week of each month.
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Orencia

Products Affected

- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML, 87.5 MG/0.7ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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

Products Affected
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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

Products Affected
- ORENITRAM

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

Orfadin

Products Affected
- ORFADIN

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

Orilissa

Products Affected
- ORILISSA ORAL TABLET 150 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 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/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 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

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The formulary is updated the first week of each month.
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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
Covered Uses	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 04, 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/Otezla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Otezla.html
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

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The formulary is updated the first week of each month.
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Otezla

Products Affected

- OTEZLA ORAL TABLET THERAPY PACK

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

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

Products Affected
- OVIDREL

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

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	

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
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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/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ml Per 1 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	
Revision Date	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	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 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 04, 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 04, 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 04, 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 04, 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
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

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
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

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral capsule*

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

2019 Aetna Small Group ACA
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

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral concentrate 100 mg/5ml*

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

2019 Aetna Small Group ACA
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 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral solution*

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

2019 Aetna Small Group ACA
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	60 MLS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet 10 mg*

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

2019 Aetna Small Group ACA
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

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
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

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
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 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	

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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

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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	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
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	Opioids may be covered up to 90 morphine milligram equivalents (MME) per day. 1) A LIFETIME APPROVAL WILL BE GRANTED WHEN: Member is terminally ill and in hospice care or has end-of-life care (other than hospice), or has an active oncology diagnosis (medication being used for treatment of cancer pain) or palliative care. 2) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: the prescriber 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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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 04, 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

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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.
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 04, 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

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 04, 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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 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 04, 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 04, 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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 2018 Quantity Limits: October 05, 2019

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 04, 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

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The formulary is updated the first week of each month.
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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	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 04, 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: April 08, 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 Affected
- PICATO

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

Pimecrolimus

Products Affected
- *pimecrolimus*

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis
Exclusion Criteria	
Required Medical Information	FOR MEMBERS LESS THAN 2 YEARS OF AGE: Covered for the treatment of mild to moderate atopic dermatitis (eczema) for short-term use (up to 3 months). FOR MEMBERS OVER 2 YEARS OF AGE: A documented diagnosis of atopic dermatitis (eczema) and has a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for their condition, or they are being treated for atopic dermatitis (eczema) in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Children 2 years & younger - 3 months; Members greater than 2 years of age - 6 months
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of med/high topical steroid. such as triamcinolone acetonide, betamethasone dipropionate
Notes/ References	
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: February 07, 2019 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
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/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
QL Criteria	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/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
QL Criteria	1 kit Per 365 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
The formulary is updated the first week of each month.
12/01/2019

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/MSInterferons.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/MSInterferons.html
QL Criteria	2 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
The formulary is updated the first week of each month.
12/01/2019

PocketChem EZ Test

Products Affected
- POCKETCHEM EZ 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

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

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/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCSK9.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: 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*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, sensitivity to amide-type local anesthetics or any other component of the product, planned use on large surface area of the body as this can lead to increased toxicity, planned area of application includes severely traumatized skin (e.g.,mucosal or skin abrasion, eczema, burns), the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), of if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for temporary anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months

PA Criteria	Criteria Details
Other Criteria	*Topical lidocaine ointment is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Approval can made up to an additional 50gms per 30 days. Higher additional quantities are not approvable *FOR ADULTS: A single application should not exceed 5 g of Lidocaine Ointment 5%, containing 250 mg of lidocaine base (equivalent chemically to approximately 300 mg of lidocaine hydrochloride). This is roughly equivalent to squeezing a six (6) inch length of ointment from the tube. In a 70 kg adult this dose equals 3.6 mg/kg (1.6 mg/lb) lidocaine base. No more than one-half tube, approximately 17-20 g of ointment or 850-1000 mg lidocaine base, should be administered in any one day. FOR CHILDREN: For children less than ten years who have a normal lean body mass and a normal lean body development, the maximum dose may be determined by the application of one of the standard pediatric drug formulas (e.g., Clark's rule). For example a child of five years weighing 50 lbs., the dose of lidocaine should not exceed 75-100 mg when calculated according to Clark's rule. In any case, the maximum amount of lidocaine administered should not exceed 4.5 mg/kg (2.0 mg/lb) of body weight ***Lidocaine toxicity resulting from transcutaneous absorption is theoretically possible. Signs and symptoms of systemic lidocaine toxicity include CNS excitation and/or depression, nervousness, confusion, dizziness, tinnitus, blurred or double vision, vomiting, twitching, tremors, seizures, unconsciousness, respiratory depression, bradycardia, hypotension, and cardiopulmonary arrest. If there is suspicion of lidocaine-related systemic toxicity, check lidocaine blood concentrations
QL Criteria	90 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prevacid 24HR

Products Affected
- PREVACID 24HR

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

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

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
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

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

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

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: There is clinical documentation indicating disease stability or improvement from baseline.
ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 04, 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

Qbrexza

Products Affected
- QBREXZA

PA Criteria	Criteria Details
Covered Uses	For topical treatment of primary axillary hyperhidrosis in adult and pediatric patients greater than 9 years old
Exclusion Criteria	Medical conditions that can be exacerbated by the anticholinergic effect of glycopyrronium (eg, glaucoma, paralytic ileus, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis, Sjogren syndrome).
Required Medical Information	A documented diagnosis of primary axillary hyperhidrosis in adult and pediatric patients greater than 9 years old. Continuation Criteria: The patient meets the Covered Uses, Required Medical Information, and Exclusion criteria AND there is clinical documentation of symptom improvement from baseline.
Age Restrictions	Greater than 9 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented contraindication, intolerance, allergy, or failure of 1 month of topical aluminum chloride.
QL Criteria	1 pad Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 10, 2018 Step Therapy: November 10, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
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 04, 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 04, 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

QUEtiapine Fumarate

Products Affected

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

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

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

QUEtiapine Fumarate

Products Affected

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

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

QUEtiapine Fumarate ER

Products Affected

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

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

QUEtiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 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
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 bottle Per 1 fill
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 04, 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/documents/2019 PPI Post Limit QL Criteria_Updated_.doc
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin for details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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
The formulary is updated the first week of each month.
12/01/2019

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/metabolic_agents.html
QL Criteria	20 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Rayaldee

Products Affected
- RAYALDEE

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

Rebif

Products Affected

- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

Rebif Rebidose

Products Affected

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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

Rebif Rebidose Titration Pack

Products Affected

- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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

Repaglinide-Metformin HCl

Products Affected

- *repaglinide-metformin hcl*

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

Repatha

Products Affected
- REPATHA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCSK9.html
QL Criteria	2 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/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCSK9.html
QL Criteria	1 syringe Per 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/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/PCSK9.html
QL Criteria	2 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 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/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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 04, 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
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

Riluzole

Products Affected
- *riluzole*

PA Criteria	Criteria Details
Covered Uses	Amyotrophic Lateral Sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 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 04, 2018 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

Risedronate Sodium

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 04, 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

Rivastigmine

Products Affected
- *rivastigmine*

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

Rivastigmine Tartrate

Products Affected
- *rivastigmine tartrate*

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

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 04, 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 04, 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/Rubraca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rubraca

Products Affected
- RUBRACA ORAL TABLET 250 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Rubraca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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
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 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

Selzentry

Products Affected
- SELZENTRY ORAL SOLUTION

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

Selzentry

Products Affected
- SELZENTRY ORAL TABLET 150 MG

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

Selzentry

Products Affected
- SELZENTRY ORAL TABLET 25 MG

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

Selzentry

Products Affected
- SELZENTRY ORAL TABLET 75 MG

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

Sensipar

Products Affected
- SENSIPAR

PA Criteria	Criteria Details
Covered Uses	Secondary hyperparathyroidism (HPT) in adult patients with chronic kidney disease (CKD) on dialysis, Hypercalcemia in adult patients with parathyroid carcinoma, or Hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy.
Exclusion Criteria	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
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: May 08, 2019

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: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

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

Signifor

Products Affected
- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 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
Covered Uses	Sickle cell anemia with recurrent moderate to severe painful crises
Exclusion Criteria	
Required Medical Information	For ages 19 years or greater, the following criteria must be met: A documented diagnosis of sickle cell anemia with recurrent moderate to severe painful crises and a documented contraindicaiton, intolerance, allergy, or failure of Droxia
Age Restrictions	Less than 2 or greater than 18 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	No prior authorization required for children 2-18 years of age. Continuation Criteria There is clinical documentation indicating disease stability or improvement for baseline.
Notes/ References	
Revision Date	Prior Authorization: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sildenafil Citrate

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 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 07, 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*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: December 31, 2018

Simvastatin

Products Affected

- *simvastatin oral tablet 40 mg*

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

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 04, 2018 Quantity Limits: August 25, 2015

Smartest Blood Glucose Test

Products Affected
- SMARTEST 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

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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	20 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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	40 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 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
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

Somatuline Depot

Products Affected
- SOMATULINE DEPOT

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

Somavert

Products Affected
- SOMAVERT

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

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 04, 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 04, 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 04, 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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Stelara

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Stelara.html
QL Criteria	2 vials Per 90 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

Stelara

Products Affected

- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Stelara.html
QL Criteria	2 syringes Per 90 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
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/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/Stelara.html
QL Criteria	2 syringes Per 60 Days
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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/miscendocrine.html
Exclusion Criteria	
Required Medical Information	
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 04, 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

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	
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

Striverdi Respimat

Products Affected
- STRIVERDI RESPIMAT

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Serevent
QL Criteria	1 inhaler Per 30 Days
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: June 04, 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: October 18, 2017

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

Supprelin LA

Products Affected
- SUPPRELIN LA

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

Sure Edge Test

Products Affected
- SURE EDGE 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

SureChek Blood Glucose Test

Products Affected

- SURECHEK 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

Sure-Test EasyPlus Mini Test

Products Affected
- SURE-TEST EASYPLUS MINI 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

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SymlinPen 60

Products Affected

- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA Approved uses
Exclusion Criteria	Poor compliance with current insulin regimen, Poor compliance with prescribed self-blood glucose monitorings, An A1C greater than 9%, Recurrent severe hypoglycemia requiring assistance during the previous 6 months, Presence of hypoglycemia unawareness, Confirmed diagnosis of gastroparesis, Need for medications that stimulate GI motility , Patient is less than 18 years old, Concurrent use with other oral antidiabetic medications (except metformin and sulfonylureas) or drugs that alter gastrointestinal motility
Required Medical Information	A documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin). For extended renewals: a documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin), and the patient demonstrated an expected reduction in HbA1c since starting this therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	initial: 6 months - extended: 12 months
Other Criteria	
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
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/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 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 04, 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
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/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tafinlar

Products Affected
- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tarceva

Products Affected
- TARCEVA ORAL TABLET 25 MG

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/Targretin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tasigna

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Antineoplastics.html
QL Criteria	4 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 04, 2018 Quantity Limits: August 25, 2015

Tazorac

Products Affected

- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

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 04, 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/Tecfidera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Tecfidera.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/Technivie.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/GI/Technivie.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/MISC/tegsedi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: December 12, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tekturna

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
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

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 04, 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

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

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

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

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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/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 25 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thalomid

Products Affected
- THALOMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/ANEOP/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: January 14, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thiola

Products Affected
- THIOLA

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

Thrive

Products Affected

- THRIVE MOUTH/THROAT GUM 2 MG

QL Criteria	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 04, 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 04, 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 04, 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

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

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral tablet extended release 24 hour*

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

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy- see required medical information
Other Criteria	A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
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 04, 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	

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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 04, 2018 Quantity Limits: August 25, 2015

Tramadol-Acetaminophen

Products Affected
- *tramadol-acetaminophen*

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

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

Treprostinil

Products Affected
- *treprostinil*

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

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 04, 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 04, 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

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

Trintellix

Products Affected
- TRINTELLIX

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

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Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: June 04, 2018 Quantity Limits: August 25, 2015

Triptodur

Products Affected
- TRIPTODUR

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

Triumeq

Products Affected
- TRIUMEQ

QL Criteria	1 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 04, 2018 Quantity Limits: August 25, 2015

TRUEtest Test

Products Affected
- TRUETEST 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

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
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 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 14, 2017 Step Therapy: June 04, 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 04, 2018 Quantity Limits: August 25, 2015

TussiCaps

Products Affected

- TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 10-8 MG

PA Criteria	Criteria Details
Covered Uses	The member is aged 18 years or older AND The member does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30) AND The member has tried and failed at least one non-opioid containing cough and cold remedy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	adults (18 years or older)
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
QL Criteria	20 caps Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: April 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

TussiCaps

Products Affected

- TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 5-4 MG

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

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/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/MUSC/bone_disease_agents.html
QL Criteria	1 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
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

UltraTRAK PRO Test

Products Affected
- ULTRATRAK PRO 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

UltraTRAK Ultimate Test

Products Affected
- ULTRATRAK ULTIMATE 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

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

Valsartan-Hydrochlorothiazide

Products Affected
- *valsartan-hydrochlorothiazide*

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

Veltassa

Products Affected
- VELTASSA

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperkalemia
Exclusion Criteria	
Required Medical Information	Documentation that a member (at least 18 years of age) has a diagnosis of chronic kidney disease (CKD) and has hyperkalemia (serum potassium level of 5.1 to greater than 6.5 mEq/L), that the member is stable on an angiotensin converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), or an aldosterone antagonist (e.g. spironolactone, eplerenone)(if taking one of the medications), the patient has been counseled to take all other oral medications 3 hours before or 3 hours after Veltassa, Veltassa will not be used as an emergency treatment for life-threatening hyperkalemia, and the member is following a low potassium diet (less than or equal to 3 grams per day).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Reauthorization criteria: Use of Veltassa has been effective in treating hyperkalemia (e.g. current serum potassium level is lower than the pretreatment baseline serum potassium level), the member continues to require treatment for hyperkalemia, the member is stable on an angiotensin converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), or an aldosterone antagonist (e.g. spironolactone, eplerenone)(if taking one of the medications) and the member continues to follow a low potassium diet (less than or equal to 3 grams per day).
QL Criteria	1 packet Per 1 Day

Notes/ References	
Revision Date	Prior Authorization: August 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 07, 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/Vemlidy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 07, 2018

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hour 150 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hour 225 mg, 37.5 mg, 75 mg*

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

Ventavis

Products Affected
- VENTAVIS

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

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg*

QL Criteria	1 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

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

PA Criteria	Criteria Details
Other Criteria	Other Criteria: A recommended consent and agreement form that can be utilized can be found at http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf. ACUTE pain is pain that comes on quickly, can be severe, but lasts a shorter period of time and requires short term treatment duration. CHRONIC pain is generally defined as pain that persists beyond acute pain triggered past the time of normal tissue healing or pain which remains even after an injury has healed or if it continues for longer than expected. References for defining pain as acute vs. chronic can be found at http://www.painmed.org/files/managing-chronic-pain.pdf, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm, and http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf.
QL Criteria	12 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 08, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vicodin 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
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
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
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

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 04, 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	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: September 24, 2018 Quantity Limits: August 25, 2015

Vigabatrin

Products Affected
- *vigabatrin oral packet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vigabatrin

Products Affected
- *vigabatrin oral tablet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vigadrone

Products Affected
- VIGADRONE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2019/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: 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 04, 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 Affected
- VIOKACE

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 04, 2018 Quantity Limits: August 25, 2015

Viread

Products Affected

- VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG

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

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
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

Voriconazole

Products Affected
- *voriconazole oral tablet*

PA Criteria	Criteria Details
Covered Uses	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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Manic or mixed episodes associated with bipolar I disorder in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Continuation Criteria: A documented diagnosis of schizophrenia or of manic or mixed episodes associated with bipolar I disorder in adults AND There is clinical documentation indicating disease stability or improvement from baseline
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER: A documented contraindication, intolerance, allergy, or failure of one generic antipsychotic (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone or ziprasidone). FOR A DIAGNOSIS OF SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of two generic antipsychotics (aripiprazole, lurasidone HCl, olanzapine, quetiapine, quetiapine ER, risperidone, ziprasidone, paliperidone er or clozapine).
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 07/2018

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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 04, 2018 Quantity Limits: August 25, 2015

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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 04, 2018 Quantity Limits: August 25, 2015

WaveSense Presto

Products Affected
- WAVESENSE PRESTO

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

Wide-Seal Diaphragm 60

Products Affected
- WIDE-SEAL DIAPHRAGM 60

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

Wide-Seal Diaphragm 65

Products Affected
- WIDE-SEAL DIAPHRAGM 65

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

Wide-Seal Diaphragm 70

Products Affected
- WIDE-SEAL DIAPHRAGM 70

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

Wide-Seal Diaphragm 75

Products Affected
- WIDE-SEAL DIAPHRAGM 75

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

Wide-Seal Diaphragm 80

Products Affected
- WIDE-SEAL DIAPHRAGM 80

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

Wide-Seal Diaphragm 85

Products Affected
- WIDE-SEAL DIAPHRAGM 85

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

Wide-Seal Diaphragm 90

Products Affected
- WIDE-SEAL DIAPHRAGM 90

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

Wide-Seal Diaphragm 95

Products Affected
- WIDE-SEAL DIAPHRAGM 95

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

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

2019 Aetna Small Group ACA
The formulary is updated the first week of each month.
12/01/2019

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

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/duputrens_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
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected
- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea.
Exclusion Criteria	
Required Medical Information	FOR HEPATIC ENCHEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 07/2018
Revision Date	Prior Authorization: August 22, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 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

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/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyrem

Products Affected
- XYREM

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

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/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2019/ENDO/gaucher_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/Zejula.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: March 01, 2019 Step Therapy: August 25, 2015 Quantity Limits: August 07, 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 04, 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 04, 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/Zepatier.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 24, 2018 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 04, 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 04, 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 04, 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
Covered Uses	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 04, 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 04, 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

Zorbtive

Products Affected
- ZORBTIVE

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