

2016 Aetna Pharmacy Drug Guide - Value Small Group Formulary  
**Abilify**

**Products Affected**

- Abilify ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR SCHIZOPHRENIA: A documented step through one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR ALL OTHER DIAGNOSIS: A documented step through one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Abilify

## Products Affected

- Abilify ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Abilify

## Products Affected

- Abilify ORAL SOLUTION

PA Criteria	Criteria Details
<b>Covered Uses</b>	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR SCHIZOPHRENIA: A documented step through one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR ALL OTHER DIAGNOSIS: A documented step through one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
<b>QL Criteria</b>	30 ML Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Abilify Discmelt

## Products Affected

- Abilify Discmelt

PA Criteria	Criteria Details
<b>Covered Uses</b>	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR SCHIZOPHRENIA: A documented step through one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) or Latuda. FOR ALL OTHER DIAGNOSIS: A documented step through one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Abilify Discmelt

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## Products Affected

- Abilify Discmelt

PA Criteria	Criteria Details
<b>Covered Uses</b>	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Absorica

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## Products Affected

- Absorica

<b>ST Criteria</b>	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Abstral

## Products Affected

- Abstral

PA Criteria	Criteria Details
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	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))

<b>ST Criteria</b>	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Acamprosate Calcium

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## Products Affected

- Acamprosate Calcium

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

# Accu-Chek Active

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## Products Affected

- Accu-Chek Active

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

# Accu-Chek Aviva

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## Products Affected

- Accu-Chek Aviva IN VITRO STRIP

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

# Accu-Chek Aviva Plus

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## Products Affected

- Accu-Chek Aviva Plus

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Aviva Plus

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## Products Affected

- Accu-Chek Aviva Plus IN VITRO

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

# Accu-Chek Compact Plus

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## Products Affected

- Accu-Chek Compact Plus

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

# Accu-Chek Compact Plus Care

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## Products Affected

- Accu-Chek Compact Plus Care

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Multiclix Lancet Dev

## Products Affected

- Accu-Chek Multiclix Lancet Dev

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Accu-Chek Nano SmartView

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## Products Affected

- Accu-Chek Nano SmartView

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek SmartView

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## Products Affected

- Accu-Chek SmartView

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

# Accu-Chek Voicemate

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## Products Affected

- Accu-Chek Voicemate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accutrend Glucose

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## Products Affected

- Accutrend Glucose

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

# Aciphex

## Products Affected

- Aciphex

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AcipHex Sprinkle

## Products Affected

- AcipHex Sprinkle

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Updated 12/2016

# Acitretin

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## Products Affected

- Acitretin

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

# Actemra

## Products Affected

- Actemra SUBCUTANEOUS\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html</a>
<b>QL Criteria</b>	4 SYRINGES Per 28 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Actemra

## Products Affected

- Actemra INTRAVENOUS\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Actiq

## Products Affected

- Actiq

PA Criteria	Criteria Details
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	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))

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<b>ST Criteria</b>	Documented trial or intolerance to two (2) immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone
<b>QL Criteria</b>	4 loz Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Activella

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## Products Affected

- Activella

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

# Actonel

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## Products Affected

- Actonel ORAL TABLET 5 MG, 30 MG

<b>ST Criteria</b>	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Actonel

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## Products Affected

- Actonel ORAL TABLET 35 MG

<b>ST Criteria</b>	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
<b>QL Criteria</b>	4 tablets Per 1 month
<b>Notes/ References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Actonel

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## Products Affected

- Actonel ORAL TABLET 150 MG

<b>ST Criteria</b>	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
<b>QL Criteria</b>	0.04 tabs Per 1 DAYS
<b>Notes/ References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Actoplus Met

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## Products Affected

- Actoplus Met

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



# Actoplus met XR

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## Products Affected

- Actoplus met XR

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

# Actos

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## Products Affected

- Actos

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

# Acura Blood Glucose Test

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## Products Affected

- Acura Blood Glucose Test

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

# Adalat CC

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## Products Affected

- Adalat CC ORAL TABLET EXTENDED  
RELEASE 24 HR\* 60 MG

<b>QL Criteria</b>	2 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Adalat CC

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## Products Affected

- Adalat CC ORAL TABLET EXTENDED  
RELEASE 24 HR\* 90 MG, 30 MG

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

# Adcirca

## Products Affected

- Adcirca

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Adderall

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## Products Affected

- Adderall

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

# Adderall XR

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## Products Affected

- Adderall XR

<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Adefovir Dipivoxil

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## Products Affected

- Adefovir Dipivoxil

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

# Adempas

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## Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Adrenaclick

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## Products Affected

- Adrenaclick INJECTION

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

# Advair Diskus

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## Products Affected

- Advair Diskus INHALATION AEROSOL  
POWDER, BREATH ACTIVATED  
100-50 MCG/DOSE, 250-50 MCG/DOSE

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

# Advair Diskus

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## Products Affected

- Advair Diskus INHALATION AEROSOL  
POWDER, BREATH ACTIVATED  
500-50 MCG/DOSE

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

# Advair HFA

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## Products Affected

- Advair HFA

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

# Advance Intuition Meter

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## Products Affected

- Advance Intuition Meter

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advance Intuition Test

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## Products Affected

- Advance Intuition Test

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



# Advate

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## Products Affected

- Advate

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advicor

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## Products Affected

- Advicor ORAL TABLET EXTENDED  
RELEASE 24 HR\* 500-20 MG, 1000-40  
MG

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

# Advicor

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## Products Affected

- Advicor ORAL TABLET EXTENDED  
RELEASE 24 HR\* 750-20 MG

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

# Advicor

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## Products Affected

- Advicor ORAL TABLET EXTENDED  
RELEASE 24 HR\* 1000-20 MG

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

# Advocate Blood Glucose Monitor

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## Products Affected

- Advocate Blood Glucose Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advocate Duo

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## Products Affected

- Advocate Duo DEVICE

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

# Advocate Redi-Code

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## Products Affected

- Advocate Redi-Code DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advocate Redi-Code

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## Products Affected

- Advocate Redi-Code IN VITRO

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



# Advocate Redi-Code+

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## Products Affected

- Advocate Redi-Code+

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advocate Redi-Code+ Test

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## Products Affected

- Advocate Redi-Code+ Test

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

# Advocate Test

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## Products Affected

- Advocate Test

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

# Adynovate

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## Products Affected

- Adynovate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Adzenys XR-ODT

## Products Affected

- Adzenys XR-ODT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)
<b>Exclusion Criteria</b>	Documentation of a diagnosis of either adult ADHD or of childhood ADHD onset with history of previous treatment and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment)
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aerospan

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## Products Affected

- Aerospan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Asthma
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Asthma
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Step Therapy. Medical Exception for Flovent Diskus and Flovent HFA: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
<b>ST Criteria</b>	Documented step through one month of ASMANEX AND QVAR
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Afeditab CR

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## Products Affected

- Afeditab CR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 30 MG

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

# Afeditab CR

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## Products Affected

- Afeditab CR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 60 MG

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



# Afinitor

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## Products Affected

- Afinitor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Afinitor Disperz

## Products Affected

- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tabs Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Afrezza

## Products Affected

- Afrezza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes, Type 2 Diabetes
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin (e.g., Levamir or Lantus), (2) In all Patients, no history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD), and (3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Afrezza

## Products Affected

- Afrezza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes, Type 2 Diabetes
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin (e.g., Levamir or Lantus), (2) In all Patients, no history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD), and (3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Afstyla

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## Products Affected

- Afstyla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AgaMatrix AMP Test

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## Products Affected

- AgaMatrix AMP Test

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

# AgaMatrix Jazz Test

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## Products Affected

- AgaMatrix Jazz Test

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

# AgaMatrix KeyNote Test

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## Products Affected

- AgaMatrix KeyNote Test

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



# AgaMatrix Presto

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## Products Affected

- AgaMatrix Presto

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AgaMatrix Presto Pro Meter

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## Products Affected

- AgaMatrix Presto Pro Meter

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AgaMatrix Presto Test

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## Products Affected

- AgaMatrix Presto Test

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

# Akynzeo

## Products Affected

- Akynzeo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Prophylaxis of chemotherapy-induced nausea and vomiting
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of nausea and vomiting associated with cancer chemotherapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>ST Criteria</b>	Documented trial of a 5HT3 receptor agonist (granisetron or ondansetron) and Emend.
<b>QL Criteria</b>	2 capsules Per 1 month
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aldara

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## Products Affected

- Aldara

<b>QL Criteria</b>	48 packet Per 112 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aldurazyme

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## Products Affected

- Aldurazyme

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Alecensa

## Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Alendronate Sodium

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## Products Affected

- Alendronate Sodium ORAL TABLET 40 MG, 5 MG, 10 MG

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



# Alendronate Sodium

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## Products Affected

- Alendronate Sodium ORAL TABLET 35 MG, 70 MG

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

# Alfuzosin HCl ER

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## Products Affected

- Alfuzosin HCl ER

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

# Almotriptan Malate

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## Products Affected

- Almotriptan Malate

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

# Alogliptin Benzoate

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## Products Affected

- Alogliptin Benzoate

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

# Alogliptin-Metformin HCl

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## Products Affected

- Alogliptin-Metformin HCl

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

# Alogliptin-Pioglitazone

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## Products Affected

- Alogliptin-Pioglitazone

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

# Alora

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## Products Affected

- Alora

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

# Alosetron HCl

## Products Affected

- Alosetron HCl

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	severe diarrhea-predominant irritable bowel syndrome (IBS)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient is female, and has a documented diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) including one or more of the following: frequent and severe abdominal pain/discomfort, frequent urgency or fecal incontinence or disability or restriction of daily activities due to IBS, AND patient has chronic IBS symptoms generally lasting 6 months or longer, AND anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial of 2 alternatives: diphenoxylate/atropine, loperamide
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Alphanate/VWF Complex/Human

## Products Affected

- Alphanate/VWF Complex/Human

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AlphaNine SD

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## Products Affected

- AlphaNine SD

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ALPRAZolam ER

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## Products Affected

- ALPRAZolam ER

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

# ALPRAZolam XR

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## Products Affected

- ALPRAZolam XR

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

# Alprolix

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## Products Affected

- Alprolix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Altavera

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## Products Affected

- Altavera

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

# Altoprev

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## Products Affected

- Altoprev

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

# Alvesco

## Products Affected

- Alvesco

PA Criteria	Criteria Details
<b>Covered Uses</b>	Asthma
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Asthma
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Step Therapy. Medical Exception for Flovent Diskus and Flovent HFA: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
<b>ST Criteria</b>	Documented step through one month of ASMANEX AND QVAR
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Alyacen 1/35

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## Products Affected

- Alyacen 1/35

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

## Alyacen 7/7/7

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### Products Affected

- Alyacen 7/7/7

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

# Ambien

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## Products Affected

- Ambien ORAL TABLET 10 MG

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

# Ambien

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## Products Affected

- Ambien ORAL TABLET 5 MG

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

# Ambien CR

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## Products Affected

- Ambien CR

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

# Amerge

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## Products Affected

- Amerge

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

# Amethia

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## Products Affected

- Amethia

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

# Amethia Lo

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## Products Affected

- Amethia Lo

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



# Amethyst

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## Products Affected

- Amethyst

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

# Amitiza

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## Products Affected

- Amitiza

<b>ST Criteria</b>	Documented step through Lactulose or Miralax
<b>QL Criteria</b>	2 capsules Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Amlodipine Besylate-Valsartan

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## Products Affected

- Amlodipine Besylate-Valsartan

<b>ST Criteria</b>	Documented step through AMLODIPINE in combination with TWO of the following: ATACAND, AVAPRO, COZAAR, MICARDIS
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Amlodipine-Atorvastatin

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## Products Affected

- Amlodipine-Atorvastatin

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

# Amnesteem

## Products Affected

- Amnesteem

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: Patient requires more than 2 capsules per day to reach the appropriate dose for weight, and this is the members FIRST course of therapy or member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month holiday), and member has recieved a cumulative dose of less than 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>ST Criteria</b>	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
<b>QL Criteria</b>	2 capsules Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Amphetamine-Dextroamphet ER

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## Products Affected

- Amphetamine-Dextroamphet ER

<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Amphetamine-Dextroamphetamine

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## Products Affected

- Amphetamine-Dextroamphetamine ORAL  
TABLET 10 MG, 12.5 MG, 7.5 MG, 15  
MG, 20 MG, 5 MG

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

# Amphetamine-Dextroamphetamine

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## Products Affected

- Amphetamine-Dextroamphetamine ORAL  
TABLET 30 MG

<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Ampyra

## Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Amturnide

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## Products Affected

- Amturnide

<b>ST Criteria</b>	Documented step thru 2 preferred ACE-I or ARB. Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril), Univasc (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan), Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AndroGel

## Products Affected

- AndroGel TRANSDERMAL GEL 20.25 MG/1.25GM (1.62%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	1 1.25 gm packet Per 1 day

<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AndroGel

## Products Affected

- AndroGel TRANSDERMAL GEL 50 MG/5GM (1%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	2 10 gm packets Per 1 day

<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AndroGel

## Products Affected

- AndroGel TRANSDERMAL GEL 25 MG/2.5GM (1%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	1 25 gram packet Per 1 day

<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# AndroGel

## Products Affected

- AndroGel TRANSDERMAL GEL 40.5 MG/2.5GM (1.62%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	5 grams-2 packets Per 1 day

<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AndroGel Pump

## Products Affected

- AndroGel Pump TRANSDERMAL GEL  
12.5 MG/ACT (1%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	10 grams Per 1 day

<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AndroGel Pump

## Products Affected

- AndroGel Pump TRANSDERMAL GEL  
20.25 MG/ACT (1.62%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	4 pumps Per 1 day

<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Angeliq

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## Products Affected

- Angeliq

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

# Anoro Ellipta

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## Products Affected

- Anoro Ellipta

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



# Antara

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## Products Affected

- Antara ORAL CAPSULE 30 MG, 90 MG

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

# Anzemet

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## Products Affected

- Anzemet ORAL

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

# APAP-Caff-Dihydrocodeine

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## Products Affected

- APAP-Caff-Dihydrocodeine ORAL  
CAPSULE

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

# Apidra

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## Products Affected

- Apidra

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Apidra SoloStar

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## Products Affected

- Apidra SoloStar SUBCUTANEOUS\*

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Apri

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## Products Affected

- Apri

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

# Apriso

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## Products Affected

- Apriso

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

# Aptensio XR

## Products Affected

- Aptensio XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)
<b>Exclusion Criteria</b>	Documentation of a diagnosis of either adult ADHD or of childhood ADHD onset with history of previous treatment and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment)
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	1 capsule Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016



# Aptiom

## Products Affected

- Aptiom ORAL TABLET 600 MG, 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Partial-onset seizure
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 TABS Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aptiom

## Products Affected

- Aptiom ORAL TABLET 800 MG, 400 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Partial-onset seizure
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 TABS Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aranelle

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## Products Affected

- Aranelle

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

# Aranesp (Albumin Free)

## Products Affected

- Aranesp (Albumin Free) INJECTION
- Aranesp (Albumin Free) INJECTION SOLUTION 10 MCG/0.4ML, 60 MCG/ML, 150 MCG/0.75ML, 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Arava

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## Products Affected

- Arava

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

# Arcalyst

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## Products Affected

- Arcalyst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Arcapta Neohaler

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## Products Affected

- Arcapta Neohaler

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic Obstructive Pulmonary Disorder (COPD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of one month of Serevent
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/References</b>	Annual Review: 07/2016
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aricept

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## Products Affected

- Aricept

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Aricept ODT

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## Products Affected

- Aricept ODT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ARIPiprazole

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## Products Affected

- ARIPiprazole ORAL SOLUTION

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

# ARIPiprazole

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## Products Affected

- ARIPiprazole ORAL TABLET 2 MG, 10 MG, 15 MG
- ARIPiprazole ORAL TABLET DISPERSIBLE

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

# Arixtra

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## Products Affected

- Arixtra

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

# Armodafinil

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 Day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Armodafinil

## Products Affected

- Armodafinil ORAL TABLET 50 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Arnuity Ellipta

## Products Affected

- Arnuity Ellipta

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Step Therapy. Medical Exception for Flovent Diskus and Flovent HFA: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Documentation of a trial and failure of Asmanex and QVAR
Notes/References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Asacol HD

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## Products Affected

- Asacol HD

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

# Ascensia Autodisc Test

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## Products Affected

- Ascensia Autodisc Test

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

# Assure 3 Test

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## Products Affected

- Assure 3 Test

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

# Assure 4 Meter

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## Products Affected

- Assure 4 Meter

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Assure 4 Test

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## Products Affected

- Assure 4 Test

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

# Assure Platinum

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## Products Affected

- Assure Platinum

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

# Assure Platinum Meter

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## Products Affected

- Assure Platinum Meter

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Assure Pro Blood Glucose Meter

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## Products Affected

- Assure Pro Blood Glucose Meter

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Assure Pro Test

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## Products Affected

- Assure Pro Test

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

# Astagraf XL

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## Products Affected

- Astagraf XL ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 0.5  
MG

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

# Astagraf XL

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## Products Affected

- Astagraf XL ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 1 MG

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

# Atacand

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## Products Affected

- Atacand ORAL TABLET 16 MG, 8 MG, 4 MG

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

# Atacand

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## Products Affected

- Atacand ORAL TABLET 32 MG

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

# Atacand HCT

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## Products Affected

- Atacand HCT ORAL TABLET 32-12.5 MG, 32-25 MG

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

# Atacand HCT

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## Products Affected

- Atacand HCT ORAL TABLET 16-12.5  
MG

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



# Atelvia

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## Products Affected

- Atelvia

<b>ST Criteria</b>	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
<b>QL Criteria</b>	4 tablets Per 1 month
<b>Notes/ References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Atorvastatin Calcium

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## Products Affected

- Atorvastatin Calcium ORAL

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

# Atripla

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## Products Affected

- Atripla

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

# Aubagio

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## Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Auvi-Q

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## Products Affected

- Auvi-Q INJECTION

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

# Avalide

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## Products Affected

- Avalide ORAL TABLET 300-12.5 MG

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

# Avalide

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## Products Affected

- Avalide ORAL TABLET 150-12.5 MG

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

# Avandamet

## Products Affected

- Avandamet ORAL TABLET 2-1000 MG

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	An adult patient with a documented diagnosis of type 2 diabetes mellitus and all of the following: unable to achieve adequate glycemic control (HbA1C lab value greater than 6.5%) despite the use of other medications, and, in consultation with their healthcare provider, has decided not to take Actos (pioglitazone) for medical reasons.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Avandamet

## Products Affected

- Avandamet ORAL TABLET 2-500 MG, 4-1000 MG, 4-500 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	An adult patient with a documented diagnosis of type 2 diabetes mellitus and all of the following: unable to achieve adequate glycemic control (HbA1C lab value greater than 6.5%) despite the use of other medications, and, in consultation with their healthcare provider, has decided not to take Actos (pioglitazone) for medical reasons.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avandaryl

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## Products Affected

- Avandaryl

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	An adult patient with a documented diagnosis of type 2 diabetes mellitus and all of the following: unable to achieve adequate glycemic control (HbA1C lab value greater than 6.5%) despite the use of other medications, and, in consultation with their healthcare provider, has decided not to take Actos (pioglitazone) for medical reasons.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avandia

## Products Affected

- Avandia

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	An adult patient with a documented diagnosis of type 2 diabetes mellitus and all of the following: unable to achieve adequate glycemic control (HbA1C lab value greater than 6.5%) despite the use of other medications, and, in consultation with their healthcare provider, has decided not to take Actos (pioglitazone) for medical reasons.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avapro

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## Products Affected

- Avapro

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

# Aviane

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## Products Affected

- Aviane

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

# AVINza

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## Products Affected

- AVINza

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

# Avita

## Products Affected

- Avita EXTERNAL GEL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Avita

## Products Affected

- Avita EXTERNAL CREAM

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	50 grams Per 1 fill
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Avodart

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## Products Affected

- Avodart

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

# Avonex

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## Products Affected

- Avonex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 doses Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Axert

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## Products Affected

- Axert

<b>QL Criteria</b>	3 tablets Per 30 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Azilect

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## Products Affected

- Azilect

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

# Azor

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## Products Affected

- Azor

<b>ST Criteria</b>	Documented step through amlodipine in combination with TWO of the following: ATACAND, AVAPRO, COZAAR, MICARDIS
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Azulfidine

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## Products Affected

- Azulfidine

<b>ST Criteria</b>	Documented step through ONE of the following: ASACOL, ASACOL HD, DELZICOL, LIALDA OR PENTASA
<b>QL Criteria</b>	8 TABS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Azulfidine EN-tabs

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## Products Affected

- Azulfidine EN-tabs

<b>ST Criteria</b>	Documented step through ONE of the following: ASACOL, ASACOL HD, DELZICOL, LIALDA OR PENTASA
<b>QL Criteria</b>	8 TABS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Azurette

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## Products Affected

- Azurette

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

# Balsalazide Disodium

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## Products Affected

- Balsalazide Disodium

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

# Balziva

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## Products Affected

- Balziva

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

# Banzel

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## Products Affected

- Banzel ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	8 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Baraclude

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## Products Affected

- Baraclude ORAL TABLET

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

# Bayer Breeze 2 Test

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## Products Affected

- Bayer Breeze 2 Test

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

# Bayer Contour Link Monitor

## Products Affected

- Bayer Contour Link Monitor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Bayer Contour Monitor

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## Products Affected

- Bayer Contour Monitor DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Monitor

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## Products Affected

- Bayer Contour Monitor KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Next EZ

## Products Affected

- Bayer Contour Next EZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour next Link

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## Products Affected

- Bayer Contour next Link

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Next Monitor

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## Products Affected

- Bayer Contour Next Monitor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Next Test

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## Products Affected

- Bayer Contour Next Test

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 strips Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Next USB Monitor

## Products Affected

- Bayer Contour Next USB Monitor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Test

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## Products Affected

- Bayer Contour Test

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 strips Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Bayer Contour USB

## Products Affected

- Bayer Contour USB

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bebulin

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## Products Affected

- Bebulin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bebulin VH

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## Products Affected

- Bebulin VH

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Beconase AQ

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## Products Affected

- Beconase AQ

<b>ST Criteria</b>	Trial of 2 weeks each of Nasonex and one of the following: Flonase, Nasalide, or Nasacort 24HR OTC
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Belbuca

## Products Affected

- Belbuca

PA Criteria	Criteria Details
<b>Covered Uses</b>	Pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
<b>Exclusion Criteria</b>	Acute or severe bronchial asthma, known or suspected gastrointestinal obstruction, including paralytic ileus
<b>Required Medical Information</b>	(1)Patient is 18 years of age or older and has a documented diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment, (2)Alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain (i.e. non-opioid analgesics or immediate-release opioids), (3)Is not being used in combination with other long-acting opioid therapy, and (4)Is NOT being used for the treatment of opioid dependence
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 films Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Belsomra

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## Products Affected

- Belsomra

<b>ST Criteria</b>	Trial of 1 month of one preferred generic alternative (zolpidem, zolpidem er, eszopiclone, zaleplon)
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# BeneFIX

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## Products Affected

- BeneFIX INTRAVENOUS\* SOLUTION  
RECONSTITUTED

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Benicar

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## Products Affected

- Benicar

<b>ST Criteria</b>	Documented step through TWO of the following: Candesartan, irbesartan, losartan and telmisartan
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Benicar HCT

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## Products Affected

- Benicar HCT

<b>ST Criteria</b>	Documented step through TWO of the following in combination with HCTZ: Candesartan, irbesartan, losartan and telmisartan
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Benlysta

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## Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/benlysta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/benlysta.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Berinert

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## Products Affected

- Berinert

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Betaseron

## Products Affected

- Betaseron SUBCUTANEOUS\* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
Exclusion 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 (15 vials) Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bethkis

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## Products Affected

- Bethkis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	56 ampules Per 30 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bevespi Aerosphere

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## Products Affected

- Bevespi Aerosphere

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic Obstructive Pulmonary Disorder (COPD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of 1 month each of Anoro Ellipta and Stiolto
<b>QL Criteria</b>	1 inhaler Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Beyaz

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## Products Affected

- Beyaz

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

# BG Star Test

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## Products Affected

- BG Star Test

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



# Bicalutamide

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## Products Affected

- Bicalutamide

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

# Bimatoprost

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## Products Affected

- Bimatoprost OPTHALMIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	open-angle glaucoma, ocular hypertension
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of glaucoma or ocular hypertension
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bivigam

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## Products Affected

- Bivigam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Boniva

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## Products Affected

- Boniva ORAL TABLET 150 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Step Therapy
<b>QL Criteria</b>	0.04 tabs Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bosulif

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## Products Affected

- Bosulif ORAL TABLET 100 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bosulif

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## Products Affected

- Bosulif ORAL TABLET 500 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Botox

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## Products Affected

- Botox

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Botox Cosmetic

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## Products Affected

- Botox Cosmetic INTRAMUSCULAR\*  
SOLUTION RECONSTITUTED 50 UNIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Bravelle

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## Products Affected

- Bravelle

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Breeze 2 Blood Glucose System

## Products Affected

- Breeze 2 Blood Glucose System

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Breo Ellipta

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## Products Affected

- Breo Ellipta INHALATION AEROSOL  
POWDER, BREATH ACTIVATED  
100-25 MCG/INH

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

# Breo Ellipta

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## Products Affected

- Breo Ellipta INHALATION AEROSOL  
POWDER, BREATH ACTIVATED  
200-25 MCG/INH

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

## Brevicon (28)

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### Products Affected

- Brevicon (28)

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

# Briellyn

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## Products Affected

- Briellyn

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

# Brilinta

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## Products Affected

- Brilinta

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

# Brintellix

## Products Affected

- Brintellix

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
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) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's 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	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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# Brisdelle

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## Products Affected

- Brisdelle

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Vasomotor symptoms associated with menopause
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of moderate to severe vasomotor symptoms associated with menopause
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 capsule Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Briviact

## Products Affected

- Briviact ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizure
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Briviact

## Products Affected

- Briviact ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizure
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Brovana

## Products Affected

- Brovana

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic Obstructive Pulmonary Disorder (COPD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of one month of Serevent
<b>QL Criteria</b>	4 milliliters Per 1 day
<b>Notes/References</b>	Annual Review: 07/2016
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Budesonide

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## Products Affected

- Budesonide INHALATION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Asthma
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For ages 5-8 documented inability to use metered dose inhalers
<b>Age Restrictions</b>	Less than 8 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Up to the age of 8
<b>Other Criteria</b>	No prior authorization required for children 1-4 years of age. Medical Exception for Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bunavail

## Products Affected

- Bunavail

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollment

PA Criteria	Criteria Details
Other Criteria	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
ST Criteria	A documented step through one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
Notes/References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Buphenyl

## Products Affected

- Buphenyl ORAL POWDER 3 GM/TSP
- Buphenyl ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Buprenorphine HCl

## Products Affected

- Buprenorphine HCl SUBLINGUAL  
TABLET SUBLINGUAL 2 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

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PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>QL Criteria</b>	0.8 tabs Per 1 Day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Buprenorphine HCl

## Products Affected

- Buprenorphine HCl SUBLINGUAL  
TABLET SUBLINGUAL 8 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

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Updated 12/2016

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: November 17, 2016

# Buprenorphine HCl-Naloxone HCl

## Products Affected

- Buprenorphine HCl-Naloxone HCl

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>QL Criteria</b>	3 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Buproban

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## Products Affected

- Buproban

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

# BuPROPion HCl

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## Products Affected

- BuPROPion HCl ORAL

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



# BuPROPion HCl ER (Smoking Det)

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## Products Affected

- BuPROPion HCl ER (Smoking Det)

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

## BuPROPion HCl ER (SR)

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### Products Affected

- BuPROPion HCl ER (SR)

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

## BuPROPion HCl ER (XL)

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### Products Affected

- BuPROPion HCl ER (XL)

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

# Butorphanol Tartrate

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## Products Affected

- Butorphanol Tartrate NASAL

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

# Butrans

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## Products Affected

- Butrans

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

# Bydureon

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## Products Affected

- Bydureon SUBCUTANEOUS\* 2 MG

<b>ST Criteria</b>	Trial and failure of 1 month each of Victoza and Trulicity
<b>QL Criteria</b>	4 pens Per 1 month
<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bydureon

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## Products Affected

- Bydureon SUBCUTANEOUS\*  
SUSPENSION RECONSTITUTED

<b>ST Criteria</b>	Trial and failure of 1 month each of Victoza and Trulicity
<b>QL Criteria</b>	4 vials Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Byetta 10 MCG Pen

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## Products Affected

- Byetta 10 MCG Pen SUBCUTANEOUS\*

<b>ST Criteria</b>	Trial and failure of 1 month each of Victoza and Trulicity
<b>QL Criteria</b>	1 pen Per 1 month
<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Byetta 5 MCG Pen

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## Products Affected

- Byetta 5 MCG Pen SUBCUTANEOUS\*

<b>ST Criteria</b>	Trial and failure of 1 month each of Victoza and Trulicity
<b>QL Criteria</b>	1 pen Per 1 month
<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bystolic

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## Products Affected

- Bystolic ORAL TABLET 10 MG, 2.5 MG, 5 MG

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

# Bystolic

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## Products Affected

- Bystolic ORAL TABLET 20 MG

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

# Byvalson

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## Products Affected

- Byvalson

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Hypertension
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of Hypertension
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through 2 generic beta-blockers and 2 generic angiotensin receptor blockers (ARBs)
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cabometyx

## Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Calcipotriene

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## Products Affected

- Calcipotriene EXTERNAL CREAM
- Calcipotriene EXTERNAL OINTMENT

<b>ST Criteria</b>	Documented step through a medium to high potency topical steroid
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Calcipotriene-Betameth Diprop

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## Products Affected

- Calcipotriene-Betameth Diprop

<b>ST Criteria</b>	Documented trial and failure of 1 medium to high potency steroid indicated for patients condition.
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Calcitonin (Salmon)

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### Products Affected

- Calcitonin (Salmon)

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



# Calcitrene

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## Products Affected

- Calcitrene

<b>ST Criteria</b>	Documented step through a medium to high potency topical steroid
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Camila

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## Products Affected

- Camila

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

# Camrese

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## Products Affected

- Camrese

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

# Camrese Lo

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## Products Affected

- Camrese Lo

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

# Canasa

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## Products Affected

- Canasa

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

# Candesartan Cilexetil

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## Products Affected

- Candesartan Cilexetil ORAL TABLET 4 MG, 8 MG, 16 MG

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

# Candesartan Cilexetil-HCTZ

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## Products Affected

- Candesartan Cilexetil-HCTZ

<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Carbaglu

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## Products Affected

- Carbaglu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cardizem LA

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## Products Affected

- Cardizem LA ORAL TABLET  
EXTENDED RELEASE 24 HR\* 240 MG

<b>QL Criteria</b>	2 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cardizem LA

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## Products Affected

- Cardizem LA ORAL TABLET  
EXTENDED RELEASE 24 HR\* 120 MG,  
360 MG

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

# Cardura XL

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## Products Affected

- Cardura XL

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

# CareSens N Glucose System

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## Products Affected

- CareSens N Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# CareSens N Glucose Test

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## Products Affected

- CareSens N Glucose Test

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

# Carimune NF

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## Products Affected

- Carimune NF INTRAVENOUS\*  
SOLUTION RECONSTITUTED 6 GM, 12  
GM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Cartia XT

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## Products Affected

- Cartia XT ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 180 MG, 120 MG,  
300 MG

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

# Cartia XT

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## Products Affected

- Cartia XT ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 240 MG

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

# Casodex

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## Products Affected

- Casodex

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

# Cayston

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## Products Affected

- Cayston

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

# Caziant

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## Products Affected

- Caziant

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

# CeleBREX

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## Products Affected

- CeleBREX

<b>QL Criteria</b>	2 CAPS Per 1 DAY
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Celecoxib

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## Products Affected

- Celecoxib ORAL

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

# CeleXA

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## Products Affected

- CeleXA ORAL TABLET

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



# Cenestin

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## Products Affected

- Cenestin ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG

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

# Cenestin

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## Products Affected

- Cenestin ORAL TABLET 1.25 MG

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

# Cerdelga

## Products Affected

- Cerdelga

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
Exclusion 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 2 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cerezyme

## Products Affected

- Cerezyme INTRAVENOUS\* SOLUTION  
RECONSTITUTED 400 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cesamet

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## Products Affected

- Cesamet

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

# Cesia

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## Products Affected

- Cesia

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

# Cetrotide

## Products Affected

- Cetrotide SUBCUTANEOUS\* KIT 0.25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cevimeline HCl

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## Products Affected

- Cevimeline HCl

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



# Chantix

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## Products Affected

- Chantix

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

# Chantix Continuing Month Pak

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## Products Affected

- Chantix Continuing Month Pak

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

# Chantix Starting Month Pak

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## Products Affected

- Chantix Starting Month Pak

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

# Chateal

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## Products Affected

- Chateal

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

# Chenodal

## Products Affected

- Chenodal

PA Criteria	Criteria Details
<b>Covered Uses</b>	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
<b>Exclusion Criteria</b>	Intrahepatic duct calculus, Chronic constipation in patients with cholesterol gallstones, Prophylaxis of recurrent gallstones, Hyperlipidemia, Rheumatoid Arthritis
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month (initial authorization), 3 month (reauthorization)
<b>Other Criteria</b>	Max authorization up to 2 years
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Cholbam

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## Products Affected

- Cholbam

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Cholbam.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Cholbam.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Chorionic Gonadotropin

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## Products Affected

- Chorionic Gonadotropin  
INTRAMUSCULAR\*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Cialis

## Products Affected

- Cialis ORAL TABLET 2.5 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	diagnosis of benign prostatic hyperplasia
<b>Exclusion Criteria</b>	Erectile dysfunction (ED) diagnosis is not covered except for members with ED benefit rider or Fully Insured (FI) members in the state of NY.
<b>Required Medical Information</b>	A documented diagnosis of diagnosis of benign prostatic hyperplasia
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year (30 tablets every 30 days)
<b>Other Criteria</b>	Member has failed two alpha blockers (e.g. Cardura (doxazosin), Hytrin (terazosin), Flomax (tamsulosin), Uroxatral (alfuzosin), Rapaflo (silodosin) and failed one 5-alpha reductase inhibitor (e.g. Avodart (dutasteride), Proscar (finasteride), Jalyn (dutasteride/tamsulosin).
<b>QL Criteria</b>	1 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cialis

## Products Affected

- Cialis ORAL TABLET 5 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	diagnosis of benign prostatic hyperplasia
<b>Exclusion Criteria</b>	Erectile dysfunction (ED) diagnosis is not covered except for members with ED benefit rider or Fully Insured (FI) members in the state of NY.
<b>Required Medical Information</b>	A documented diagnosis of diagnosis of benign prostatic hyperplasia
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year (30 tablets every 30 days)
<b>Other Criteria</b>	Member has failed two alpha blockers (e.g. Cardura (doxazosin), Hytrin (terazosin), Flomax (tamsulosin), Uroxatral (alfuzosin), Rapaflo (silodosin) and failed one 5-alpha reductase inhibitor (e.g. Avodart (dutasteride), Proscar (finasteride), Jalyn (dutasteride/tamsulosin).
<b>QL Criteria</b>	1 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 07/2016
<b>Revision Date</b>	Prior Authorization: April 22, 2016 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html</a>
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cimzia Prefilled

## Products Affected

- Cimzia Prefilled

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html</a>
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cimzia Starter Kit

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## Products Affected

- Cimzia Starter Kit

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html</a>
<b>QL Criteria</b>	1 kit Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cinqair

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## Products Affected

- Cinqair

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/RESP/Cinqair.html">http://www.aetna.com/products/rxnonmedicare/data/2016/RESP/Cinqair.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cinryze

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## Products Affected

- Cinryze

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Citalopram Hydrobromide

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## Products Affected

- Citalopram Hydrobromide ORAL  
TABLET 10 MG, 20 MG

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



# Citalopram Hydrobromide

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## Products Affected

- Citalopram Hydrobromide ORAL  
TABLET 40 MG

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

# Claravis

## Products Affected

- Claravis

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: Patient requires more than 2 capsules per day to reach the appropriate dose for weight, and this is the members FIRST course of therapy or member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month holiday), and member has recieved a cumulative dose of less than 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>ST Criteria</b>	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
<b>QL Criteria</b>	2 capsules Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Updated 12/2016

# Clarinet

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## Products Affected

- Clarinet ORAL TABLET

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

# Clarinet-D 12 Hour

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## Products Affected

- Clarinet-D 12 Hour

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

## Clever Chek Auto-Code

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### Products Affected

- Clever Chek Auto-Code

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

# Clever Chek Auto-Code System

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## Products Affected

- Clever Chek Auto-Code System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clever Chek Auto-Code Test

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## Products Affected

- Clever Chek Auto-Code Test

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

# Clever Chek Auto-Code Voice

---

## Products Affected

- Clever Chek Auto-Code Voice

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Clever Chek Auto-Code Voice

---

## Products Affected

- Clever Chek Auto-Code Voice IN VITRO

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

# Clever Chek Test

---

## Products Affected

- Clever Chek Test

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

# Clever Choice Auto-Code System

---

## Products Affected

- Clever Choice Auto-Code System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Clever Choice Auto-Code Test

---

### Products Affected

- Clever Choice Auto-Code Test

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

# Clever Choice Micro System

## Products Affected

- Clever Choice Micro System

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clever Choice Micro Test

---

## Products Affected

- Clever Choice Micro Test

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

# Clever Choice Mini System

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## Products Affected

- Clever Choice Mini System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Climara

---

## Products Affected

- Climara

<b>QL Criteria</b>	0.15 patch Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Climara Pro

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## Products Affected

- Climara Pro

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

# CloNIDine HCl ER

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## Products Affected

- CloNIDine HCl ER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)Note: diagnosis criteria only applies to members greater than 18 years old. Step therapy requirement applies to all member regardless of age.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clopidogrel Bisulfate

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## Products Affected

- Clopidogrel Bisulfate

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

# CloZAPine

---

## Products Affected

- CloZAPine ORAL TABLET  
DISPERSIBLE 200 MG

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

<b>QL Criteria</b>	9 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

<b>QL Criteria</b>	3 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# CloZAPine

---

## Products Affected

- CloZAPine ORAL TABLET 200 MG

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



# CloZAPine

---

## Products Affected

- CloZAPine ORAL TABLET  
DISPERSIBLE 150 MG

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

# Clozaril

---

## Products Affected

- Clozaril ORAL TABLET 100 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	9 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clozaril

---

## Products Affected

- Clozaril ORAL TABLET 25 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	3 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Coagadex

## Products Affected

- Coagadex

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Colazal

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## Products Affected

- Colazal

<b>QL Criteria</b>	9 caps Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Colchicine

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## Products Affected

- Colchicine ORAL TABLET

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

# Colcrys

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## Products Affected

- Colcrys

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

# Colyte with Flavor Packs

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## Products Affected

- Colyte with Flavor Packs ORAL  
SOLUTION RECONSTITUTED 227.1  
GM

<b>QL Criteria</b>	4 liters Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# CombiPatch

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## Products Affected

- CombiPatch

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

## Cometriq (100 mg Daily Dose)

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### Products Affected

- Cometriq (100 mg Daily Dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 kits Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Cometriq (140 mg Daily Dose)

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### Products Affected

- Cometriq (140 mg Daily Dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
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: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Cometriq (60 mg Daily Dose)

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### Products Affected

- Cometriq (60 mg Daily Dose)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 kits Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Complera

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## Products Affected

- Complera

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

# Concerta

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## Products Affected

- Concerta ORAL TABLET  
EXTENDEDRELEASE\* 27 MG, 54 MG,  
18 MG

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

# Concerta

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## Products Affected

- Concerta ORAL TABLET  
EXTENDEDRELEASE\* 36 MG

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

# Control AST

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## Products Affected

- Control AST

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



# Control Test

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## Products Affected

- Control Test

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

# Copaxone

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## Products Affected

- Copaxone SUBCUTANEOUS\* 20 MG/ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cordran

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## Products Affected

- Cordran EXTERNAL TAPE

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

# Coreg CR

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## Products Affected

- Coreg CR

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

# Corifact

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## Products Affected

- Corifact

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Corlanor

## Products Affected

- Corlanor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	FDA labeled use for heart failure
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 than or equal to 70 beats per minute, and who are on maximally tolerated doses of beta-blockers (bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate/metoprolol succinate-HCTZ, nebivolol) or have a documented contraindication to beta-blocker use.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented trial of one month of one of the following: ACE Inhibitor or ACE Inhibitor/HCTZ combination or Angiotensin-Receptor Blocker or Angiotensin-Receptor Blocker/HCTZ combination
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: July 25, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cosentyx

## Products Affected

- Cosentyx

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cosentyx Sensoready Pen

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## Products Affected

- Cosentyx Sensoready Pen  
SUBCUTANEOUS\* 150 MG/ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cosentyx.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Cotellic

## Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	63 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cozaar

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## Products Affected

- Cozaar ORAL TABLET 50 MG, 25 MG

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

# Crestor

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## Products Affected

- Crestor

<b>ST Criteria</b>	A documented step through two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cryselle-28

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## Products Affected

- Cryselle-28

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

# CVS Nicotine

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## Products Affected

- CVS Nicotine TRANSDERMAL PATCH  
24 HR 7 MG/24HR, 14 MG/24HR

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

# CVS Nicotine Polacrilex

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## Products Affected

- CVS Nicotine Polacrilex  
MOUTH/THROAT LOZENGE 4 MG

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

# CVS NTS Step 1

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## Products Affected

- CVS NTS Step 1

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

# Cyclafem 1/35

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## Products Affected

- Cyclafem 1/35

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



## Cyclafem 7/7/7

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### Products Affected

- Cyclafem 7/7/7

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

# Cyclessa

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## Products Affected

- Cyclessa

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

# Cycloset

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## Products Affected

- Cycloset

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

# Cymbalta

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## Products Affected

- Cymbalta ORAL CAPSULE DELAYED  
RELEASE PARTICLES 30 MG

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

# Cymbalta

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## Products Affected

- Cymbalta ORAL CAPSULE DELAYED  
RELEASE PARTICLES 20 MG

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

# Cymbalta

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## Products Affected

- Cymbalta ORAL CAPSULE DELAYED  
RELEASE PARTICLES 60 MG

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

# Cystagon

## Products Affected

- Cystagon

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cystaran

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## Products Affected

- Cystaran

<b>QL Criteria</b>	2 ML Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
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

# Daliresp

## Products Affected

- Daliresp

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Severe COPD (GOLD stage 3 or 4)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of severe (Stage III) or very severe (StageIV) chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and a history of exacerbations
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial of 2 preferred alternatives: Dulera, Symbicort, Spiriva, Incruse, Anoro, or Stiolto
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Darifenacin Hydrobromide ER

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## Products Affected

- Darifenacin Hydrobromide ER

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

# Dasetta 1/35

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## Products Affected

- Dasetta 1/35

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

## Dasetta 7/7/7

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### Products Affected

- Dasetta 7/7/7

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

# Daysee

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## Products Affected

- Daysee

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

# Daytrana

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## Products Affected

- Daytrana

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



# Deblitane

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## Products Affected

- Deblitane

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

# Delzicol

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## Products Affected

- Delzicol

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

# Depo-Provera

---

## Products Affected

- Depo-Provera INTRAMUSCULAR\*  
SUSPENSION 150 MG/ML

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

# Depo-SubQ Provera 104

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## Products Affected

- Depo-SubQ Provera 104  
SUBCUTANEOUS\* SUSPENSION

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

# Descovy

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## Products Affected

- Descovy

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

# Desloratadine

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## Products Affected

- Desloratadine

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

# Desogen

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## Products Affected

- Desogen

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

# Desoxyn

## Products Affected

- Desoxyn

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of ADHD or Narcolepsy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	4 tablets Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Desvenlafaxine ER

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## Products Affected

- Desvenlafaxine ER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 TB24 Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Desvenlafaxine Fumarate ER

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## Products Affected

- Desvenlafaxine Fumarate ER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 TB24 Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Detrol LA

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## Products Affected

- Detrol LA

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

# Dexedrine

## Products Affected

- Dexedrine ORAL CAPSULE EXTENDED RELEASE 24 HOUR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit disorder, Attention deficit hyperactivity disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of adult ADD or ADHD OR documentation of a diagnosis of childhood ADHD onset with history of previous treatment, and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	3 CAPS Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

# Dexedrine

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## Products Affected

- Dexedrine ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of ADHD or Narcolepsy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tabs Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dexilant

## Products Affected

- Dexilant

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dexmethylphenidate HCl

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## Products Affected

- Dexmethylphenidate HCl

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

# Dexmethylphenidate HCl ER

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## Products Affected

- Dexmethylphenidate HCl ER ORAL  
CAPSULE EXTENDED RELEASE 24  
HOUR 30 MG, 10 MG, 5 MG, 15 MG, 40  
MG

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



# Dextroamphetamine Sulfate

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## Products Affected

- Dextroamphetamine Sulfate ORAL  
TABLET

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

# Dextroamphetamine Sulfate

---

## Products Affected

- Dextroamphetamine Sulfate ORAL SOLUTION

<b>QL Criteria</b>	40 milliliters Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dextroamphetamine Sulfate ER

## Products Affected

- Dextroamphetamine Sulfate ER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Attention deficit disorder, Attention deficit hyperactivity disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of adult ADD or ADHD OR documentation of a diagnosis of childhood ADHD onset with history of previous treatment, and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Diazepam

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## Products Affected

- Diazepam GEL

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

# Diclegis

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## Products Affected

- Diclegis

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

# Diclofenac Sodium

---

## Products Affected

- Diclofenac Sodium TRANSDERMAL  
GEL 1 %

<b>QL Criteria</b>	200 GM Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Diclofenac Sodium

---

## Products Affected

- Diclofenac Sodium TRANSDERMAL SOLUTION

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

# Differin

---

## Products Affected

- Differin EXTERNAL GEL 0.3 %
- Differin EXTERNAL LOTION

<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Dificid

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## Products Affected

- Dificid

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

# Dihydroergotamine Mesylate

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## Products Affected

- Dihydroergotamine Mesylate NASAL

<b>QL Criteria</b>	8 bottles Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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 180  
MG, 120 MG

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

# Diltiazem CD

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## Products Affected

- Diltiazem CD ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 240  
MG

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

# Diltiazem HCl ER

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## Products Affected

- Diltiazem HCl ER ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 120  
MG, 180 MG
- Diltiazem HCl ER ORAL CAPSULE  
EXTENDED RELEASE 12 HOUR 120  
MG

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

# Diltiazem HCl ER

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## Products Affected

- Diltiazem HCl ER ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 240  
MG

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

# Diltiazem HCl ER Beads

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## Products Affected

- Diltiazem HCl ER Beads ORAL  
CAPSULE EXTENDED RELEASE 24  
HOUR 120 MG, 180 MG, 300 MG, 420  
MG, 360 MG

<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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



# Diltiazem HCl ER Coated Beads

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## Products Affected

- Diltiazem HCl ER Coated Beads ORAL  
CAPSULE EXTENDED RELEASE 24  
HOUR 360 MG, 180 MG, 300 MG, 120  
MG

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

# Diltiazem HCl ER Coated Beads

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## Products Affected

- Diltiazem HCl ER Coated Beads ORAL  
CAPSULE EXTENDED RELEASE 24  
HOUR 240 MG

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

# Dilt-XR

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## Products Affected

- Dilt-XR ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 120 MG, 180 MG

<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# Diovan

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## Products Affected

- Diovan

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

# Diovan HCT

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## Products Affected

- Diovan HCT

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

# Dipentum

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## Products Affected

- Dipentum

<b>ST Criteria</b>	Documented step through ONE of the following: ASACOL, ASACOL HD, DELZICOL, LIALDA OR PENTASA
<b>QL Criteria</b>	4 capsules Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ditropan XL

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## Products Affected

- Ditropan XL

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



# Dolophine

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## Products Affected

- Dolophine

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

# Donepezil HCl

## Products Affected

- Donepezil HCl ORAL TABLET 5 MG, 23 MG
- Donepezil HCl ORAL TABLET DISPERSIBLE

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Donepezil HCl

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## Products Affected

- Donepezil HCl ORAL TABLET 10 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dovonex

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## Products Affected

- Dovonex EXTERNAL CREAM

<b>ST Criteria</b>	Documented step through a medium to high potency topical steroid
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dronabinol

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## Products Affected

- Dronabinol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Drospirenone-Ethinyl Estradiol

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## Products Affected

- Drospirenone-Ethinyl Estradiol ORAL  
TABLET 3-0.03 MG

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

# Duavee

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## Products Affected

- Duavee

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

# Duetact

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## Products Affected

- Duetact

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



# Dulera

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## Products Affected

- Dulera

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

# DULoxetine HCl

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## Products Affected

- DULoxetine HCl ORAL CAPSULE  
DELAYED RELEASE PARTICLES 30  
MG

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

# DULoxetine HCl

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## Products Affected

- DULoxetine HCl ORAL CAPSULE  
DELAYED RELEASE PARTICLES 20  
MG

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

# DULoxetine HCl

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## Products Affected

- DULoxetine HCl ORAL CAPSULE  
DELAYED RELEASE PARTICLES 60  
MG

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

# Duragesic-100

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## Products Affected

- Duragesic-100

<b>QL Criteria</b>	20 patches Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duragesic-12

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## Products Affected

- Duragesic-12

<b>QL Criteria</b>	20 patches Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duragesic-25

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## Products Affected

- Duragesic-25

<b>QL Criteria</b>	20 patches Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duragesic-50

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## Products Affected

- Duragesic-50

<b>QL Criteria</b>	20 patches Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Duragesic-75

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## Products Affected

- Duragesic-75

<b>QL Criteria</b>	20 patches Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dutasteride

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## Products Affected

- Dutasteride

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

# Dyanavel XR

## Products Affected

- Dyanavel XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)
<b>Exclusion Criteria</b>	Documentation of a diagnosis of either adult ADHD or of childhood ADHD onset with history of previous treatment and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment)
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	240 ML Per 30 days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dysport

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## Products Affected

- Dysport

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Plus II Glucose System

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## Products Affected

- Easy Plus II Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Plus II Glucose Test

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## Products Affected

- Easy Plus II Glucose Test

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

# Easy Step Glucose Monitor

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## Products Affected

- Easy Step Glucose Monitor DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Step Test

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## Products Affected

- Easy Step Test

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



# Easy Talk Blood Glucose System

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## Products Affected

- Easy Talk Blood Glucose System DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Talk Blood Glucose Test

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## Products Affected

- Easy Talk Blood Glucose Test

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

# Easy Touch Test

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## Products Affected

- Easy Touch Test

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

# Easy Trak Blood Glucose Test

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## Products Affected

- Easy Trak Blood Glucose Test

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

# EasyGluco

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## Products Affected

- EasyGluco IN VITRO

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

# EasyMax 15 Test

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## Products Affected

- EasyMax 15 Test

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

# EasyMax L Blood Glucose

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## Products Affected

- EasyMax L Blood Glucose DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyMax N Blood Glucose

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## Products Affected

- EasyMax N Blood Glucose DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# EasyMax NG Blood Glucose

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## Products Affected

- EasyMax NG Blood Glucose DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EASYMax Test

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## Products Affected

- EASYMax Test

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

# EasyMax V Blood Glucose

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## Products Affected

- EasyMax V Blood Glucose DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyMax V2 Blood Glucose

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## Products Affected

- EasyMax V2 Blood Glucose DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyPlus Blood Glucose Test

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## Products Affected

- EasyPlus Blood Glucose Test

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

# EasyPRO Plus

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## Products Affected

- EasyPRO Plus IN VITRO

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

# Edarbi

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## Products Affected

- Edarbi

<b>ST Criteria</b>	Documented step through TWO of the following: Candesartan, irbesartan, losartan and telmisartan
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Edarbyclor

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## Products Affected

- Edarbyclor

<b>ST Criteria</b>	Documented step through TWO of the following in combination with HCTZ: Candesartan, irbesartan, losartan and telmisartan
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Edurant

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## Products Affected

- Edurant

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

# Effexor XR

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## Products Affected

- Effexor XR ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 150  
MG

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

# Effexor XR

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## Products Affected

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

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

# Effient

## Products Affected

- Effient

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI].
<b>Exclusion Criteria</b>	History of Stroke or TIA
<b>Required Medical Information</b>	Member has a documented diagnosis of acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI]) managed by percutaneous coronary intervention (PCI) AND Member has no prior history of stroke or transient ischemic attack (TIA)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Egrifta

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## Products Affected

- Egrifta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Elaprase

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## Products Affected

- Elaprase

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Elelyso

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## Products Affected

- Elelyso

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Element Plus

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## Products Affected

- Element Plus

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Element Test

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## Products Affected

- Element Test

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

# Elestrin

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## Products Affected

- Elestrin

<b>QL Criteria</b>	52 GM Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Elidel

## Products Affected

- Elidel

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required), or a documented diagnosis of atopic dermatitis (eczema) in an adult or child 2 years of age or older with one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

# Elinest

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## Products Affected

- Elinest

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

# Ella

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## Products Affected

- Ella

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

# Eloctate

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## Products Affected

- Eloctate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Embeda

## Products Affected

- Embeda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	A documented step through one month each of two preferred alternatives which include Butrans, Hysingla ER, and Oxycontin
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Embrace Blood Glucose Monitor

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## Products Affected

- Embrace Blood Glucose Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Embrace Blood Glucose Test

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## Products Affected

- Embrace Blood Glucose Test

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

# Emend

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## Products Affected

- Emend ORAL CAPSULE 40 MG, 125 MG, 80 MG

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

# Emend

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## Products Affected

- Emend ORAL CAPSULE 80 & 125 MG

<b>QL Criteria</b>	3 tri-packs Per 30 months
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EMLA

## Products Affected

- EMLA

PA Criteria	Criteria Details
<b>Covered Uses</b>	***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 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
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	*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.

<b>QL Criteria</b>	30 GM Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Emoquette

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## Products Affected

- Emoquette

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

# Emsam

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## Products Affected

- Emsam

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

# Emtriva

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## Products Affected

- Emtriva ORAL CAPSULE

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



# Enablex

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## Products Affected

- Enablex

<b>ST Criteria</b>	Documented trial of 2 preferred alternatives: Vesicare OR Myrbetriq AND one generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
<b>QL Criteria</b>	1 tablet Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Enablex

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## Products Affected

- Enablex

<b>ST Criteria</b>	Documented trial of 2 preferred alternatives: Vesicare OR Myrbetriq AND one generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Enbrel

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## Products Affected

- Enbrel SUBCUTANEOUS\* 25 MG/0.5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 syringes Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Enbrel

## Products Affected

- Enbrel SUBCUTANEOUS\* KIT
- Enbrel SUBCUTANEOUS\* 50 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Enbrel SureClick

## Products Affected

- Enbrel SureClick SUBCUTANEOUS\*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Enjuvia

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## Products Affected

- Enjuvia ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG

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

# Enjuvia

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## Products Affected

- Enjuvia ORAL TABLET 1.25 MG

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

# Enoxaparin Sodium

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## Products Affected

- Enoxaparin Sodium

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



# Enpresse-28

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## Products Affected

- Enpresse-28

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

# Entecavir

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## Products Affected

- Entecavir

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

# Entecavir

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## Products Affected

- Entecavir

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

# Entresto

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## Products Affected

- Entresto

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Heart Failure
<b>Exclusion Criteria</b>	Known or suspected pregnancy
<b>Required Medical Information</b>	A documented diagnosis of chronic heart failure (NYHA Class II-IV)and reduced ejection fraction
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 08/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Entyvio

## Products Affected

- Entyvio

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Entyvio.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Entyvio.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Entyvio.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Entyvio.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Epaned

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## Products Affected

- Epaned

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A. Documentation of an inability to swallow
<b>Age Restrictions</b>	13 years or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Covered without prior authorization for those 12 years of age or younger
<b>Notes/References</b>	Annual Review: 08/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Epclusa

## Products Affected

- Epclusa

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Epiduo

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## Products Affected

- Epiduo

<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Epiduo Forte

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## Products Affected

- Epiduo Forte

<b>ST Criteria</b>	Documented step through Retin-A
<b>QL Criteria</b>	45 gm Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EPINEPHrine

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## Products Affected

- EPINEPHrine INJECTION 0.15 MG/0.15ML, 0.3 MG/0.3ML

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

# Epogen

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## Products Affected

- Epogen INJECTION SOLUTION 20000 UNIT/ML, 4000 UNIT/ML, 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Eprosartan Mesylate

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## Products Affected

- Eprosartan Mesylate

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

# EQ Nicotine

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## Products Affected

- EQ Nicotine TRANSDERMAL

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

# EQL Nicotine

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## Products Affected

- EQL Nicotine TRANSDERMAL

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

# Erivedge

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## Products Affected

- Erivedge

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Errin

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## Products Affected

- Errin

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



# Esbriet

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## Products Affected

- Esbriet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Idiopathic_Pulmonary_Fibrosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Idiopathic_Pulmonary_Fibrosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	9 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Escitalopram Oxalate

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## Products Affected

- Escitalopram Oxalate ORAL SOLUTION

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

# Escitalopram Oxalate

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## Products Affected

- Escitalopram Oxalate ORAL TABLET 10 MG

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

# Escitalopram Oxalate

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## Products Affected

- Escitalopram Oxalate ORAL TABLET 20 MG, 5 MG

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

# Esomeprazole Magnesium

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## Products Affected

- Esomeprazole Magnesium ORAL  
CAPSULE DELAYED RELEASE 40 MG

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

# Estraderm

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## Products Affected

- Estraderm

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

# Estradiol

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## Products Affected

- Estradiol TRANSDERMAL PATCH  
WEEKLY 0.0375 MG/24HR, 0.06  
MG/24HR, 0.025 MG/24HR, 0.1  
MG/24HR, 0.075 MG/24HR

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

# Estradiol

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## Products Affected

- Estradiol TRANSDERMAL PATCH  
BIWEEKLY

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



# Estradiol

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## Products Affected

- Estradiol TRANSDERMAL PATCH  
WEEKLY 0.05 MG/24HR

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

# Estradiol-Norethindrone Acet

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## Products Affected

- Estradiol-Norethindrone Acet

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

# Estrogel

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## Products Affected

- Estrogel

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

# Estrostep Fe

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## Products Affected

- Estrostep Fe

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

# Eszopiclone

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## Products Affected

- Eszopiclone

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

# Euflexxa

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## Products Affected

- Euflexxa INTRA-ARTICULAR\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Evamist

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## Products Affected

- Evamist

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

# Evekeo

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## Products Affected

- Evekeo

<b>QL Criteria</b>	120 tablets Per 30 Days
<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# EvenCare + Blood Glucose Test

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## Products Affected

- EvenCare + Blood Glucose Test

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

# EvenCare Blood Glucose Test

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## Products Affected

- EvenCare Blood Glucose Test

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

# EvenCare G2 Monitor

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## Products Affected

- EvenCare G2 Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EvenCare G2 Test

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## Products Affected

- EvenCare G2 Test

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

# EvenCare G3 Monitor

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## Products Affected

- EvenCare G3 Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EvenCare G3 Test

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## Products Affected

- EvenCare G3 Test

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

# Evolution Autocode

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## Products Affected

- Evolution Autocode

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Evolution Autocode

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## Products Affected

- Evolution Autocode IN VITRO

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



# Evoxac

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## Products Affected

- Evoxac

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

# Exalgo

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## Products Affected

- Exalgo ORAL 32 MG, 12 MG, 8 MG

<b>QL Criteria</b>	2 tablets Per 2 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exalgo

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## Products Affected

- Exalgo ORAL 16 MG

<b>QL Criteria</b>	4 tablets Per 2 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exelon

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## Products Affected

- Exelon TRANSDERMAL
- Exelon ORAL CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exforge

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## Products Affected

- Exforge

<b>ST Criteria</b>	Documented step through AMLODIPINE in combination with TWO of the following: ATACAND, AVAPRO, COZAAR, MICARDIS
<b>QL Criteria</b>	1 TABS Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exforge HCT

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## Products Affected

- Exforge HCT

<b>ST Criteria</b>	Documented step through amlodipine with 2 of the following (brand or generic if available): Atacand HCT, Avalide, Hyzaar, Micardis HCT
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exjade

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## Products Affected

- Exjade

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
Exclusion 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 (15 vials) Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Ez Smart Blood Glucose Test

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## Products Affected

- Ez Smart Blood Glucose Test

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

# Ez Smart Monitoring System

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## Products Affected

- Ez Smart Monitoring System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ez Smart Plus Glucose Test

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## Products Affected

- Ez Smart Plus Glucose Test

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

# Ez Smart Plus Monitoring Sys

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## Products Affected

- Ez Smart Plus Monitoring Sys

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fabior

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## Products Affected

- Fabior

<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fabrazyme

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## Products Affected

- Fabrazyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FaLessa

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## Products Affected

- FaLessa ORAL KIT 20-1-0.1 MCG-MG

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

# Falmina

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## Products Affected

- Falmina

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



# Famciclovir

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## Products Affected

- Famciclovir ORAL TABLET 250 MG, 125 MG

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

# Famciclovir

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## Products Affected

- Famciclovir ORAL TABLET 500 MG

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

# Famvir

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## Products Affected

- Famvir ORAL TABLET 500 MG

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

# Famvir

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## Products Affected

- Famvir ORAL TABLET 125 MG, 250 MG

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

# Fanapt

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## Products Affected

- Fanapt

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fanapt

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## Products Affected

- Fanapt

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fanapt Titration Pack

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## Products Affected

- Fanapt Titration Pack

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	0.27 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fanapt Titration Pack

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## Products Affected

- Fanapt Titration Pack

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	0.27 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Farxiga

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## Products Affected

- Farxiga

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

# Farydak

## Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 EA Per 30 Days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FazaClo

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## Products Affected

- FazaClo ORAL TABLET DISPERSIBLE  
25 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	3 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FazaClo

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## Products Affected

- FazaClo ORAL TABLET DISPERSIBLE  
150 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	6 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FazaClo

---

## Products Affected

- FazaClo ORAL TABLET DISPERSIBLE  
12.5 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	1 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FazaClo

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## Products Affected

- FazaClo ORAL TABLET DISPERSIBLE  
100 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	9 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FazaClo

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## Products Affected

- FazaClo ORAL TABLET DISPERSIBLE  
200 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Feiba

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## Products Affected

- Feiba

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Feiba NF

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## Products Affected

- Feiba NF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Feiba VH Immuno

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## Products Affected

- Feiba VH Immuno

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Felodipine ER

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## Products Affected

- Felodipine ER

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

# Femcon Fe

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## Products Affected

- Femcon Fe

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

# Femhrt Low Dose

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## Products Affected

- Femhrt Low Dose

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

# Femring

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## Products Affected

- Femring

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

# Fenofibrate

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## Products Affected

- Fenofibrate ORAL TABLET 54 MG, 48 MG, 145 MG, 160 MG

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

# Fenofibrate

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## Products Affected

- Fenofibrate ORAL CAPSULE

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



# Fenofibrate Micronized

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## Products Affected

- Fenofibrate Micronized

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

# Fenofibric Acid

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## Products Affected

- Fenofibric Acid ORAL TABLET

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

# FentaNYL

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## Products Affected

- FentaNYL

<b>QL Criteria</b>	20 patches Per 30 months
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FentaNYL Citrate

## Products Affected

- FentaNYL Citrate BUCCAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	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))

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

<b>ST Criteria</b>	Documented trial or intolerance to two (2) immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone
<b>QL Criteria</b>	4 lozenges Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fentora

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## Products Affected

- Fentora BUCCAL TABLET 600 MCG, 100 MCG, 200 MCG, 400 MCG, 800 MCG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
<b>ST Criteria</b>	<p>Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge</p>
<b>QL Criteria</b>	<p>4 tabs Per 1 Day</p>
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: October 10, 2016  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Ferriprox

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## Products Affected

- Ferriprox

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Fetzima

## Products Affected

- Fetzima

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Diagnosis of major depressive disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	Documented step through THREE different antidepressants from at least TWO different therapeutic subclasses, i.e., SSRIs (FLUOXETINE, CITALOPRAM), SNRIs (DULOXETINE, VENLAFAXINE), TCAs (AMITRIPTYLINE, NORTRIPTYLINE), Heterocyclic Antidepressants (MIRTAZAPINE, TRAZODONE)
QL Criteria	1 CP24 Per 1 DAYS
Notes/References	Annual Review: 05/2016
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fetzima Titration

## Products Affected

- Fetzima Titration

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Diagnosis of major depressive disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	Documented step through THREE different antidepressants from at least TWO different therapeutic subclasses, i.e., SSRIs (FLUOXETINE, CITALOPRAM), SNRIs (DULOXETINE, VENLAFAXINE), TCAs (AMITRIPTYLINE, NORTRIPTYLINE), Heterocyclic Antidepressants (MIRTAZAPINE, TRAZODONE)
QL Criteria	1 CP24 Per 1 DAYS
Notes/References	Annual Review: 05/2016
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fibricor

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## Products Affected

- Fibricor

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

# Fifty50 Glucose Test 2.0

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## Products Affected

- Fifty50 Glucose Test 2.0

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

# Firazyr

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## Products Affected

- Firazyr

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	3 syringes Per 1 fill
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Flebogamma

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## Products Affected

- Flebogamma INTRAVENOUS\*  
SOLUTION 0.5 GM/10ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Flebogamma DIF

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## Products Affected

- Flebogamma DIF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Flolan

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## Products Affected

- Flolan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Flovent Diskus

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## Products Affected

- Flovent Diskus

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Step Therapy. Medical Exception for Flovent Diskus and Flovent HFA: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Documented step through one month of ASMANEX AND QVAR
QL Criteria	2 diskus Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Flovent HFA

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## Products Affected

- Flovent HFA

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Step Therapy. Medical Exception for Flovent Diskus and Flovent HFA: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Documented step through one month of ASMANEX AND QVAR
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Flunisolide

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## Products Affected

- Flunisolide NASAL SOLUTION 25 MCG/ACT (0.025%)

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

# Fluocinonide

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## Products Affected

- Fluocinonide EXTERNAL CREAM 0.1 %

<b>ST Criteria</b>	Documented step through TWO VERY HIGH POTENCY TOPICAL STEROIDS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FLUoxetine HCl

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## Products Affected

- FLUoxetine HCl ORAL CAPSULE 20 MG

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

# FLUoxetine HCl

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## Products Affected

- FLUoxetine HCl ORAL CAPSULE 40 MG

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

# FLUoxetine HCl

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## Products Affected

- FLUoxetine HCl ORAL CAPSULE  
DELAYED RELEASE

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

# FLUoxetine HCl

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## Products Affected

- FLUoxetine HCl ORAL CAPSULE 10 MG

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



# FLUoxetine HCl

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## Products Affected

- FLUoxetine HCl ORAL TABLET 10 MG

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

# FLUoxetine HCl

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## Products Affected

- FLUoxetine HCl ORAL TABLET 60 MG

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

# FLUoxetine HCl

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## Products Affected

- FLUoxetine HCl ORAL TABLET 20 MG

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

# FLUoxetine HCl (PMDD)

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## Products Affected

- FLUoxetine HCl (PMDD) ORAL  
CAPSULE 10 MG

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

# FLUoxetine HCl (PMDD)

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## Products Affected

- FLUoxetine HCl (PMDD) ORAL  
CAPSULE 20 MG

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

# Fluvastatin Sodium

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## Products Affected

- Fluvastatin Sodium

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

# FluvoxaMINE Maleate

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## Products Affected

- FluvoxaMINE Maleate ORAL TABLET  
25 MG, 50 MG

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

# FluvoxaMINE Maleate

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## Products Affected

- FluvoxaMINE Maleate ORAL TABLET  
100 MG

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



# Fluvoxamine Maleate ER

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## Products Affected

- Fluvoxamine Maleate ER

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

# Focalin

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## Products Affected

- Focalin

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

# Focalin XR

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## Products Affected

- Focalin XR

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

# Follistim AQ

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## Products Affected

- Follistim AQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fondaparinux Sodium

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## Products Affected

- Fondaparinux Sodium

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

# FORA D10 2-in-1 Monitor

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## Products Affected

- FORA D10 2-in-1 Monitor

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

# FORA D10 Blood Glucose Test

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## Products Affected

- FORA D10 Blood Glucose Test

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

# FORA D15g 2-in-1 Monitor

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## Products Affected

- FORA D15g 2-in-1 Monitor

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



# FORA D15g Blood Glucose Test

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## Products Affected

- FORA D15g Blood Glucose Test

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

# FORA D20 2-in-1 Monitor

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## Products Affected

- FORA D20 2-in-1 Monitor

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

# FORA D20 Blood Glucose Test

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## Products Affected

- FORA D20 Blood Glucose Test

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

# FORA G20 Blood Glucose Test

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## Products Affected

- FORA G20 Blood Glucose Test

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

# FORA G30a Blood Glucose System

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## Products Affected

- FORA G30a Blood Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA G30a Blood Glucose Test

---

## Products Affected

- FORA G30a Blood Glucose Test

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

# Fora GD20 Blood Glucose System

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## Products Affected

- Fora GD20 Blood Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fora GD20 Test

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## Products Affected

- Fora GD20 Test

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



# FORA V10 Blood Glucose System

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## Products Affected

- FORA V10 Blood Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V10 Blood Glucose Test

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## Products Affected

- FORA V10 Blood Glucose Test

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

# FORA V12 Blood Glucose System

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## Products Affected

- FORA V12 Blood Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V12 Blood Glucose Test

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## Products Affected

- FORA V12 Blood Glucose Test

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

# FORA V20 Blood Glucose System

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## Products Affected

- FORA V20 Blood Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V20 Blood Glucose Test

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## Products Affected

- FORA V20 Blood Glucose Test

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

# FORA V30a Blood Glucose System

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## Products Affected

- FORA V30a Blood Glucose System  
DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V30a Blood Glucose Test

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## Products Affected

- FORA V30a Blood Glucose Test

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



# ForaCare GD40 Monitor

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## Products Affected

- ForaCare GD40 Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ForaCare GD40 Test

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## Products Affected

- ForaCare GD40 Test

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

# ForaCare premium V10

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## Products Affected

- ForaCare premium V10

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ForaCare premium V10 Test

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## Products Affected

- ForaCare premium V10 Test

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

# Foradil Aerolizer

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## Products Affected

- Foradil Aerolizer

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

# Forteo

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## Products Affected

- Forteo SUBCUTANEOUS\* SOLUTION  
600 MCG/2.4ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fortical

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## Products Affected

- Fortical

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

# Fosamax

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## Products Affected

- Fosamax ORAL TABLET 70 MG

<b>QL Criteria</b>	0.15 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Fosamax Plus D

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## Products Affected

- Fosamax Plus D

<b>ST Criteria</b>	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
<b>QL Criteria</b>	4 tablets Per 1 month
<b>Notes/ References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fragmin

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## Products Affected

- Fragmin

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

# FreeStyle Flash System

## Products Affected

- FreeStyle Flash System

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FreeStyle Freedom Lite

## Products Affected

- FreeStyle Freedom Lite

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FreeStyle InsuLinx System

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## Products Affected

- FreeStyle InsuLinx System

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FreeStyle InsuLinx Test

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## Products Affected

- FreeStyle InsuLinx Test

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

# FreeStyle Lite

## Products Affected

- FreeStyle Lite

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FreeStyle Lite Test

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## Products Affected

- FreeStyle Lite Test

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



# FreeStyle System

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## Products Affected

- FreeStyle System

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Frova

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## Products Affected

- Frova

<b>ST Criteria</b>	Documented step through one month of THREE of the following: NARATRIPTAN, RIZATRIPTAN, SUMATRIPTAN, ZOLMITRIPTAN
<b>QL Criteria</b>	9 tablets Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Frovatriptan Succinate

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## Products Affected

- Frovatriptan Succinate

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

# Fulyzaq

## Products Affected

- Fulyzaq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Diarrhea
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Fulyzaq is covered for adult members who meet the following criteria: (1) Diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month, and (2) Currently taking antiviral therapy with adherence of at least 80%, and (3) Documentation of unsatisfactory effects with, intolerance to, or inability to take at least one anti-motility agent (loperamide, diphenoxylate/atropine, bismuth subsalicylate) or one or more watery bowel movements per day without regular ADM use.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: October 25, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fycompa

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## Products Affected

- Fycompa ORAL SUSPENSION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Partial-onset seizure disorder with and without secondary generalized seizures
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A. Documentation of use as adjunct therapy with 1 or more other FDA approved Anti-Epileptic Drugs (AED)
<b>Age Restrictions</b>	12 years and greater
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fycompa

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## Products Affected

- Fycompa ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Partial-onset seizure disorder with and without secondary generalized seizures
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A. Documentation of use as adjunct therapy with 1 or more other FDA approved Anti-Epileptic Drugs (AED)
<b>Age Restrictions</b>	12 years and greater
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 TABS Per 1 DAYS
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gabapentin

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## Products Affected

- Gabapentin ORAL CAPSULE

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

# Gabapentin

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## Products Affected

- Gabapentin ORAL SOLUTION 250 MG/5ML

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



# Gabapentin

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## Products Affected

- Gabapentin ORAL TABLET

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

# Gabitril

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## Products Affected

- Gabitril ORAL TABLET 16 MG

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

# Gabril

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## Products Affected

- Gabril ORAL TABLET 4 MG, 12 MG

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

# Gabril

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## Products Affected

- Gabril ORAL TABLET 2 MG

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

# Galantamine Hydrobromide

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## Products Affected

- Galantamine Hydrobromide ORAL  
TABLET

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gammagard

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## Products Affected

- Gammagard

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gammagard S/D Less IgA

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## Products Affected

- Gammagard S/D Less IgA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gammaked

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## Products Affected

- Gammaked

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Gammaplex

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## Products Affected

- Gammaplex

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gamunex-C

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## Products Affected

- Gamunex-C

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ganirelix Acetate

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## Products Affected

- Ganirelix Acetate

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Gattex.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Gattex.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# GaviLyte-C

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## Products Affected

- GaviLyte-C

<b>QL Criteria</b>	4 liters Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# GaviLyte-G

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## Products Affected

- GaviLyte-G

<b>QL Criteria</b>	4 liters Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# GE100 Blood Glucose Test

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## Products Affected

- GE100 Blood Glucose Test

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

# Gelnique

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## Products Affected

- Gelnique

<b>ST Criteria</b>	Documented trial of 2 preferred alternatives: Vesicare OR Myrbetriq AND one generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Gel-One

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## Products Affected

- Gel-One INTRA-ARTICULAR\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gelsyn-3

## Products Affected

- Gelsyn-3

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Generess FE

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## Products Affected

- Generess FE

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

# Genotropin

## Products Affected

- Genotropin

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Genotropin MiniQuick

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## Products Affected

- Genotropin MiniQuick

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Genvoya

## Products Affected

- Genvoya

PA Criteria	Criteria Details
<b>Covered Uses</b>	Human Immunodeficiency Virus (HIV)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A. A documented resistance test within the past 3 months demonstrating virologic susceptibility to all of the following components of Stribild: elvitegravir, emtricitabine, and tenofovir AND; 1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Atripla (efavirenz-emtricitabine-tenofovir) or a documented resistance test within the past 3 months demonstrating virologic resistance to efavirenz, OR; 2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Truvada, Reyataz, and Norvir (emtricitabine-tenofovir, atazanavir, ritonavir) in combination or documented resistance test within the past 3 months demonstrating virological resistance to atazanavir.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year, extended approval upon Review every 1 year meeting the following criteria: A documented
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Geodon

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## Products Affected

- Geodon ORAL

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	2 CAPS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gianvi

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## Products Affected

- Gianvi

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



# Giazo

## Products Affected

- Giazo

PA Criteria	Criteria Details
<b>Covered Uses</b>	Ulcerative colitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild to moderate ulcerative colitis in males. Note: Per Product Labeling, Giazo effectiveness was not demonstrated in female patients.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented step through one month of APRISO, ASACOL, ASACOL HD, DELZICOL, LIALDA, OR PENTASA
<b>QL Criteria</b>	6 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gildagia

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## Products Affected

- Gildagia

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

## Gildess 1.5/30

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### Products Affected

- Gildess 1.5/30

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

# Gildess 1/20

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## Products Affected

- Gildess 1/20

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

## Gildess FE 1.5/30

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### Products Affected

- Gildess FE 1.5/30

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

## Gildess FE 1/20

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### Products Affected

- Gildess FE 1/20

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

# Gilenya

## Products Affected

- Gilenya

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Relapsing forms of multiple sclerosis (MS)
<b>Exclusion Criteria</b>	Primary progressive MS AND combination use of interferons and/or Copaxone and/or Gilenya and/or Aubagio and/or Tysabri
<b>Required Medical Information</b>	Obtain baseline ECG within the last 6 months for patients at higher risk of bradyarrhythmia (patients receiving Class Ia or Class III antiarrhythmics, low heart rate, history of syncope, sick sinus syndrome, 2nd degree or higher conduction block, ischemic
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	For new starts, documentation of step through or intolerance to Extavia
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Gleevec

## Products Affected

- Gleevec ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gleevec

## Products Affected

- Gleevec ORAL TABLET 400 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# GlucaGen Diagnostic

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## Products Affected

- GlucaGen Diagnostic

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

# GlucaGen HypoKit

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## Products Affected

- GlucaGen HypoKit

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

# Glucocard 01 Blood Glucose

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## Products Affected

- Glucocard 01 Blood Glucose DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glucocard 01 Sensor Plus

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## Products Affected

- Glucocard 01 Sensor Plus

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

# Glucocard Expression Test

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## Products Affected

- Glucocard Expression Test

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

# Glucocard Vital Test

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## Products Affected

- Glucocard Vital Test

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



# Glucocard X-Sensor

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## Products Affected

- Glucocard X-Sensor

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

# GlucoCom Blood Glucose Monitor

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## Products Affected

- GlucoCom Blood Glucose Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# GlucoCom Test

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## Products Affected

- GlucoCom Test

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

# Glyxambi

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## Products Affected

- Glyxambi

<b>ST Criteria</b>	A documented step through one month each of Invokana/Invokamet and either Januvia/Janumet or Onglyza/Kombiglyze
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gonal-f

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## Products Affected

- Gonal-f

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gonal-f RFF

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## Products Affected

- Gonal-f RFF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gonal-f RFF Pen

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## Products Affected

- Gonal-f RFF Pen

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gonal-f RFF Rediject

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## Products Affected

- Gonal-f RFF Rediject

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Gralise

## Products Affected

- Gralise ORAL TABLET 300 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Post-Herpetic neuralgia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented step through one month of GABAPENTIN
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gralise

## Products Affected

- Gralise ORAL TABLET 600 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Post-Herpetic neuralgia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented step through one month of GABAPENTIN
<b>QL Criteria</b>	3 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gralise Starter

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## Products Affected

- Gralise Starter

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Post-Herpetic neuralgia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented step through one month of GABAPENTIN
<b>QL Criteria</b>	1 starter pack Per 1 month
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Granisetron HCl

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## Products Affected

- Granisetron HCl ORAL

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

# GuanFACINE HCl ER

## Products Affected

- GuanFACINE HCl ER

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)Note: diagnosis criteria only applies to members greater than 18 years old. Step therapy requirement applies to all member regardless of age.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through CLONIDINE, CLONIDINE SR, GUANFACINE, AMPHETAMINE/DEXTROAMPHETAMINE, AMPHETAMINE/DEXTROAMPHETAMINE SR, DEXMETHYLPHENIDATE, DEXMETHYLPHENIDATE SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE, METHYLPHENIDATE ER, METHYLPHENIDATE SR, STRATTERA, or VYVANSE
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Harvoni

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## Products Affected

- Harvoni

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Heather

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## Products Affected

- Heather

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

# Helixate FS

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## Products Affected

- Helixate FS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Hemangeol

## Products Affected

- Hemangeol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	infantile hemangioma
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) Documented diagnosis of proliferating infantile hemangioma requiring systemic therapy, and (2) Documentation that the member was not born prematurely with a corrected age of less than 5 weeks, and (3) Documentation that the member does not weight less than 2kg, have sustained heart rate of less than 80 beats per minutes, have greater than first degree heart block, or have decompensated heart failure, and (4) Member does not have sustained blood pressure less than 50/30mmHg
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hemofil M

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## Products Affected

- Hemofil M INTRAVENOUS\* SOLUTION  
 RECONSTITUTED 1501-2000 UNIT,  
 801-1500 UNIT, 1000 UNIT, 1700 UNIT,  
 401-800 UNIT, 500 UNIT, 220-400 UNIT,  
 250 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hepsera

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## Products Affected

- Hepsera

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

# Hetlioz

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## Products Affected

- Hetlioz

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Non-24 sleep wake-disorder
<b>Exclusion Criteria</b>	Documentation of concimant sleep disorders (sleep apnea, insomnia)
<b>Required Medical Information</b>	Documentation of non-24 sleep wake-disorder, and documentation of total-blindness with no light perception, and documentation of at least 3 months of difficulty initiating sleep, difficulty awakening in the morning, or excessive daytimes sleepiness.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hizentra

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## Products Affected

- Hizentra SUBCUTANEOUS\* SOLUTION  
1 GM/5ML, 4 GM/20ML, 2 GM/10ML, 10 GM/50ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# HM Nicotine

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## Products Affected

- HM Nicotine

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

# HM Nicotine Polacrilex

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## Products Affected

- HM Nicotine Polacrilex  
MOUTH/THROAT LOZENGE 2 MG

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

# Horizant

## Products Affected

- Horizant ORAL TABLET  
EXTENDEDRELEASE\* 600 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Post-herpetic neuralgia and Restless leg syndrome
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FOR POST-HERPETIC NEURALGIA: Documentation of a step through Neurontin. FOR RESTLESS LEG SYNDROME: Documentation of a step through 2 of the following: Neurontin, Requip, Mirapex
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Horizant

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## Products Affected

- Horizant ORAL TABLET  
EXTENDEDRELEASE\* 300 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Post-herpetic neuralgia and Restless leg syndrome
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FOR POST-HERPETIC NEURALGIA: Documentation of a step through Neurontin. FOR RESTLESS LEG SYNDROME: Documentation of a step through 2 of the following: Neurontin, Requip, Mirapex
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humate-P

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## Products Affected

- Humate-P INTRAVENOUS\* SOLUTION  
RECONSTITUTED 1000-2400 UNIT,  
250-600 UNIT, 500-1200 UNIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humatrope

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## Products Affected

- Humatrope

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humira

## Products Affected

- Humira SUBCUTANEOUS\* 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 kit (2 pens)s
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humira

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## Products Affected

- Humira SUBCUTANEOUS\* 10  
MG/0.2ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humira

## Products Affected

- Humira SUBCUTANEOUS\* 20 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 injections Per 28 kit (2 pens)s
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humira Pediatric Crohns Start

## Products Affected

- Humira Pediatric Crohns Start  
SUBCUTANEOUS\* 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
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 21 months
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humira Pen

## Products Affected

- Humira Pen SUBCUTANEOUS\*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 kit (2 pens)s
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Humira Pen-Crohns Starter

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## Products Affected

- Humira Pen-Crohns Starter  
SUBCUTANEOUS\*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
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 21 months
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Humira Pen-Psoriasis Starter

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## Products Affected

- Humira Pen-Psoriasis Starter  
SUBCUTANEOUS\*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 months
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hyalgan

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## Products Affected

- Hyalgan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hycamtin

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## Products Affected

- Hycamtin ORAL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hydrocod Polst-CPM Polst ER

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## Products Affected

- Hydrocod Polst-CPM Polst ER ORAL  
LIQUID EXTENDEDRELEASE\*

<b>QL Criteria</b>	120 milliliters Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# HYDROmorphone HCl ER

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## Products Affected

- HYDROmorphone HCl ER ORAL 16 MG

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

# HYDRORmorphone HCl ER

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## Products Affected

- HYDRORmorphone HCl ER ORAL 32 MG, 8 MG, 12 MG

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

# Hymovis

## Products Affected

- Hymovis

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Hyqvia

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## Products Affected

- Hyqvia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hysingla ER

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## Products Affected

- Hysingla ER

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

# Ibandronate Sodium

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## Products Affected

- Ibandronate Sodium ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Step Therapy
<b>QL Criteria</b>	1 tablet Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ibandronate Sodium

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## Products Affected

- Ibandronate Sodium INTRAVENOUS\*  
SOLUTION 3 MG/3ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ibrance

## Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	21 EA Per 28 Days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Iclusig

## Products Affected

- Iclusig ORAL TABLET 15 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Idelvion

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## Products Affected

- Idelvion

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Ilaris

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## Products Affected

- Ilaris

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Imatinib Mesylate

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## Products Affected

- Imatinib Mesylate ORAL TABLET 400 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Imbruvica

## Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Imiquimod

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## Products Affected

- Imiquimod EXTERNAL

<b>QL Criteria</b>	48 packets Per 112 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Imitrex

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## Products Affected

- Imitrex NASAL SOLUTION 5 MG/ACT

<b>QL Criteria</b>	0.21 ml Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Imitrex

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## Products Affected

- Imitrex ORAL

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

# Imitrex

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## Products Affected

- Imitrex SUBCUTANEOUS\*

<b>QL Criteria</b>	8 vials Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 14, 2016



# Imitrex

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## Products Affected

- Imitrex NASAL SOLUTION 20 MG/ACT

<b>QL Criteria</b>	0.27 ml Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Impavido

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## Products Affected

- Impavido

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Leishmaniasis
<b>Exclusion Criteria</b>	Known or suspected pregnancy
<b>Required Medical Information</b>	A documented diagnosis of any of the following leishmaniasis infections: Visceral leishmaniasis due to <i>Leishmania donovani</i> , Cutaneous leishmaniasis due to <i>Leishmania braziliensis</i> , <i>Leishmania guyanensis</i> , and <i>Leishmania panamensis</i> , or Mucosal leishmaniasis due to <i>Leishmania braziliensis</i>
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	28 days
<b>Other Criteria</b>	
<b>QL Criteria</b>	84 capsules Per 28 days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 16, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Implanon

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## Products Affected

- Implanon

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

# Increlex

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## Products Affected

- Increlex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Increlex.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Increlex.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Inderal XL

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## Products Affected

- Inderal XL ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 80 MG

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

# Infinity Blood Glucose Test

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## Products Affected

- Infinity Blood Glucose Test

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

# Inlyta

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## Products Affected

- Inlyta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# InnoPran XL

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## Products Affected

- InnoPran XL ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 80 MG

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



# InnoPran XL

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## Products Affected

- InnoPran XL ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 120  
MG

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

# Intelligence

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## Products Affected

- Intelligence ORAL TABLET 100 MG, 25 MG

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

# Intelligence

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## Products Affected

- Intelligence ORAL TABLET 200 MG

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

# Intron A

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## Products Affected

- Intron A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Introvale

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## Products Affected

- Introvale

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

# Intuniv

## Products Affected

- Intuniv

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)Note: diagnosis criteria only applies to members greater than 18 years old. Step therapy requirement applies to all member regardless of age.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through CLONIDINE, CLONIDINE SR, GUANFACINE, AMPHETAMINE/DEXTROAMPHETAMINE, AMPHETAMINE/DEXTROAMPHETAMINE SR, DEXMETHYLPHENIDATE, DEXMETHYLPHENIDATE SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE, METHYLPHENIDATE ER, METHYLPHENIDATE SR, STRATTERA, or VYVANSE
<b>QL Criteria</b>	1 TABS Per 1 DAY
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

# Invega

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## Products Affected

- Invega ORAL TABLET EXTENDED  
RELEASE 24 HR\* 6 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Invega

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## Products Affected

- Invega ORAL TABLET EXTENDED  
RELEASE 24 HR\* 3 MG, 1.5 MG, 9 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Invokamet

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## Products Affected

- Invokamet

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

# Invokamet XR

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## Products Affected

- Invokamet XR

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

# Invokana

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## Products Affected

- Invokana

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

# Ipratropium Bromide

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## Products Affected

- Ipratropium Bromide NASAL

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

# Iprivask

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## Products Affected

- Iprivask

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

# Irbesartan

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## Products Affected

- Irbesartan

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

# Irbesartan-Hydrochlorothiazide

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## Products Affected

- Irbesartan-Hydrochlorothiazide

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

# Irenka

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## Products Affected

- Irenka

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



# Iressa

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## Products Affected

- Iressa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Isentress

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## Products Affected

- Isentress ORAL TABLET

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

# ISENTRESS

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## Products Affected

- ISENTRESS ORAL TABLET CHEWABLE

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

# Itraconazole

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## Products Affected

- Itraconazole ORAL

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

# Ixinity

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## Products Affected

- Ixinity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Jadenu

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## Products Affected

- Jadenu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Jakafi

## Products Affected

- Jakafi ORAL TABLET 5 MG, 25 MG, 15 MG, 20 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Jakafi

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## Products Affected

- Jakafi ORAL TABLET 10 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Janumet

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## Products Affected

- Janumet

<b>QL Criteria</b>	999 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Janumet XR

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## Products Affected

- Janumet XR

<b>QL Criteria</b>	999 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Janumet XR

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## Products Affected

- Janumet XR

<b>QL Criteria</b>	999 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Januvia

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## Products Affected

- Januvia

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

# Jardiance

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## Products Affected

- Jardiance

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

# Jentaduetto

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## Products Affected

- Jentaduetto

<b>ST Criteria</b>	A documented step through one month each of Januvia, Janumet, or Janumet XR, and either Onglyza or Kombiglyze XR
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Jentaduetto XR

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## Products Affected

- Jentaduetto XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 5-1000  
MG

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

# Jentaduetto XR

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## Products Affected

- Jentaduetto XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 2.5-1000  
MG

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



# Jinteli

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## Products Affected

- Jinteli

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

# Jolessa

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## Products Affected

- Jolessa

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

# Jolivette

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## Products Affected

- Jolivette

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	(1)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, and (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative such as terbinafine, itraconazole, griseofulvin, or fluconazole defined as (a) 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 (b) Presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or (c) Member is female and is pregnant and/or breastfeeding
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 07/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Junel 1.5/30

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## Products Affected

- Junel 1.5/30

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

# Junel 1/20

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## Products Affected

- Junel 1/20

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

# Junel FE 1.5/30

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## Products Affected

- Junel FE 1.5/30

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

# Junel FE 1/20

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## Products Affected

- Junel FE 1/20

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



# Juxtapid

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## Products Affected

- Juxtapid ORAL CAPSULE 40 MG, 60 MG, 30 MG

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

# Juxtapid

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## Products Affected

- Juxtapid ORAL CAPSULE 10 MG, 5 MG

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

# Kadian

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## Products Affected

- Kadian

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

# Kalbitor

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## Products Affected

- Kalbitor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kalydeco

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## Products Affected

- Kalydeco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kalydeco

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## Products Affected

- Kalydeco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kanuma

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## Products Affected

- Kanuma

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kapvay

## Products Affected

- Kapvay ORAL TABLET EXTENDED RELEASE 12 HR\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)Note: diagnosis criteria only applies to members greater than 18 years old. Step therapy requirement applies to all member regardless of age.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through CLONIDINE, CLONIDINE SR, GUANFACINE, AMPHETAMINE/DEXTROAMPHETAMINE, AMPHETAMINE/DEXTROAMPHETAMINE SR, DEXMETHYLPHENIDATE, DEXMETHYPHENIDATE SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE, METHYLPHENIDATE ER, METHYLPHENIDATE SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	4 tabs Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016



# Karbinal ER

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## Products Affected

- Karbinal ER ORAL LIQUID  
EXTENDEDRELEASE\*

<b>ST Criteria</b>	Documented step through OTC Claritin, Zyrtec, or Allengra, and Carbinoxamine
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kariva

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## Products Affected

- Kariva

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

# Kazano

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## Products Affected

- Kazano

<b>ST Criteria</b>	Documented step through 1 month each of 2 preferred alternatives: Januvia and Onglyza (single entity or combination)
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kelnor 1/35

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## Products Affected

- Kelnor 1/35

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

# Keppra XR

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## Products Affected

- Keppra XR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 750 MG

<b>QL Criteria</b>	4 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Keppra XR

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## Products Affected

- Keppra XR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 500 MG

<b>QL Criteria</b>	6 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kerydin

## Products Affected

- Kerydin

PA Criteria	Criteria Details
<b>Covered Uses</b>	onychomycosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1)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, and (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative such as terbinafine, itraconazole, griseofulvin, or fluconazole defined as (a) 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 (b) Presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis), or (c) Member is female and is pregnant and/or breastfeeding
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 07/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ketoconazole

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## Products Affected

- Ketoconazole ORAL

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



# Ketorolac Tromethamine

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## Products Affected

- Ketorolac Tromethamine ORAL

<b>QL Criteria</b>	20 tablets Per 28 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ketorolac Tromethamine

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## Products Affected

- Ketorolac Tromethamine OPTHALMIC

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

# Keveyis

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## Products Affected

- Keveyis

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

# Khedezla

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## Products Affected

- Khedezla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 TB24 Per 1 DAYS
<b>Notes/References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kineret

## Products Affected

- Kineret SUBCUTANEOUS\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Kineret.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Kineret.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Kineret.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Kineret.html</a>
<b>QL Criteria</b>	1 syringe Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Koate-DVI

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## Products Affected

- Koate-DVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kogenate FS

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## Products Affected

- Kogenate FS

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kogenate FS Bio-Set

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## Products Affected

- Kogenate FS Bio-Set

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Kombiglyze XR

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## Products Affected

- Kombiglyze XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 5-500  
MG, 5-1000 MG

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

# Kombiglyze XR

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## Products Affected

- Kombiglyze XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 2.5-1000  
MG

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

# Korlym

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## Products Affected

- Korlym

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

# Kovaltry

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## Products Affected

- Kovaltry

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kroger Blood Glucose

## Products Affected

- Kroger Blood Glucose KIT w/Device

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kroger Blood Glucose Test

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## Products Affected

- Kroger Blood Glucose Test

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

# Kroger Premium Blood Glucose

## Products Affected

- Kroger Premium Blood Glucose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kroger Premium Glucose Test

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## Products Affected

- Kroger Premium Glucose Test

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



# Kroger Test

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## Products Affected

- Kroger Test

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

# Kurvelo

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## Products Affected

- Kurvelo

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

# Kuvan

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## Products Affected

- Kuvan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kynamro

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## Products Affected

- Kynamro SUBCUTANEOUS\*

<b>QL Criteria</b>	4 SOLN Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LaMICtal ODT

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## Products Affected

- LaMICtal ODT ORAL TABLET  
DISPERSIBLE 200 MG, 100 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Epilepsy, Bipolar I Disorder (only for ODT formulation)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine OR lamotrigine ER
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LaMICtal ODT

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## Products Affected

- LaMICtal ODT ORAL TABLET  
DISPERSIBLE 25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Epilepsy, Bipolar I Disorder (only for ODT formulation)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine OR lamotrigine ER
<b>QL Criteria</b>	6 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LaMICtal ODT

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## Products Affected

- LaMICtal ODT ORAL TABLET  
DISPERSIBLE 50 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial and failure of 1 month of lamotrigine OR lamotrigine ER
QL Criteria	3 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LaMICtal XR

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## Products Affected

- LaMICtal XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Epilepsy, Bipolar I Disorder (only for ODT formulation)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine ir
<b>QL Criteria</b>	3 TB24 Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# LaMICtal XR

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## Products Affected

- LaMICtal XR ORAL KIT

<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine ir
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LaMICtal XR

## Products Affected

- LaMICtal XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 25 MG,  
50 MG, 100 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial and failure of 1 month of lamotrigine ir
QL Criteria	1 TB24 Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LaMICtal XR

## Products Affected

- LaMICtal XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 250 MG,  
300 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial and failure of 1 month of lamotrigine ir
QL Criteria	2 TB24 Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LamISIL

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## Products Affected

- LamISIL ORAL PACKET 187.5 MG

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

# LamISIL

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## Products Affected

- LamISIL ORAL PACKET 125 MG

<b>QL Criteria</b>	2 packs Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Epilepsy, Bipolar I Disorder (only for ODT formulation)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine ir
<b>QL Criteria</b>	2 TAB Per 1 DAILY
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LamoTRIGine

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## Products Affected

- LamoTRIGine ORAL TABLET  
DISPERSIBLE 25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Epilepsy, Bipolar I Disorder (only for ODT formulation)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine ir
<b>QL Criteria</b>	6 TAB Per 1 DAILY
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LamoTRIGine

## Products Affected

- LamoTRIGine ORAL TABLET DISPERSIBLE 50 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial and failure of 1 month of lamotrigine ir
QL Criteria	3 TAB Per 1 DAILY
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# LamoTRIGine ER

## Products Affected

- LamoTRIGine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Epilepsy, Bipolar I Disorder (only for ODT formulation)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine ir
<b>QL Criteria</b>	3 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LamoTRIGine ER

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## Products Affected

- LamoTRIGine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 300 MG,  
250 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial and failure of 1 month of lamotrigine ir
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LamoTRIGine ER

## Products Affected

- LamoTRIGine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 50 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Epilepsy, Bipolar I Disorder (only for ODT formulation)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial and failure of 1 month of lamotrigine ir
<b>QL Criteria</b>	1 TB24 Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LamoTRIGine ER

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## Products Affected

- LamoTRIGine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 100 MG,  
25 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial and failure of 1 month of lamotrigine ir
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lansoprazole

## Products Affected

- Lansoprazole ORAL CAPSULE  
DELAYED RELEASE

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

# Lantus

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## Products Affected

- Lantus

<b>ST Criteria</b>	A documented step through one month of Levemir
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lantus SoloStar

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## Products Affected

- Lantus SoloStar SUBCUTANEOUS\*

<b>ST Criteria</b>	A documented step through one month of Levemir
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Larin Fe 1.5/30

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## Products Affected

- Larin Fe 1.5/30

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



# Latuda

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## Products Affected

- Latuda ORAL TABLET 40 MG, 120 MG, 20 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Latuda

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## Products Affected

- Latuda ORAL TABLET 60 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Latuda

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## Products Affected

- Latuda ORAL TABLET 80 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lazanda

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## Products Affected

- Lazanda NASAL SOLUTION 300 MCG/ACT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
<b>ST Criteria</b>	<p>Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge</p>
<b>QL Criteria</b>	<p>4 bottles Per 30 days</p>
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: October 10, 2016  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Lazanda

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## Products Affected

- Lazanda NASAL SOLUTION 400 MCG/ACT, 100 MCG/ACT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
<b>ST Criteria</b>	<p>Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge</p>
<b>QL Criteria</b>	<p>15 bottles Per 1 fill</p>
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: October 10, 2016  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Leena

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## Products Affected

- Leena

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



# Leflunomide

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## Products Affected

- Leflunomide ORAL

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

# Lemtrada

## Products Affected

- Lemtrada

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	6 ML Per 365 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lenvima 10 MG Daily Dose

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## Products Affected

- Lenvima 10 MG Daily Dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lenvima 14 MG Daily Dose

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## Products Affected

- Lenvima 14 MG Daily Dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lenvima 18 MG Daily Dose

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## Products Affected

- Lenvima 18 MG Daily Dose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Prevention of acute or delayed nausea or vomiting associated with initial and repeat courses of moderately and highly emetogenic cancer chemotherapy and prevention of postoperative nausea and vomiting (PONV) for up to 24 hours following surgery
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 days Per 1 fill
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 23, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lenvima 20 MG Daily Dose

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## Products Affected

- Lenvima 20 MG Daily Dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lenvima 24 MG Daily Dose

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## Products Affected

- Lenvima 24 MG Daily Dose

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lenvima 8 MG Daily Dose

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## Products Affected

- Lenvima 8 MG Daily Dose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Prevention of acute or delayed nausea or vomiting associated with initial and repeat courses of moderately and highly emetogenic cancer chemotherapy and prevention of postoperative nausea and vomiting (PONV) for up to 24 hours following surgery
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 days Per 1 fill
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 23, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Lescol XL

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## Products Affected

- Lescol XL

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

# Lessina

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## Products Affected

- Lessina

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

# Letairis

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## Products Affected

- Letairis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Leuprolide Acetate

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## Products Affected

- Leuprolide Acetate INJECTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Levalbuterol Tartrate HFA

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## Products Affected

- Levalbuterol Tartrate HFA

<b>ST Criteria</b>	Documented step through one week each of VENTOLIN HFA AND PROAIR
<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: November 09, 2016 Quantity Limits: August 25, 2015

# LevETIRAcetam ER

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## Products Affected

- LevETIRAcetam ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 500 MG

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

# LevETIRAcetam ER

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## Products Affected

- LevETIRAcetam ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 750 MG

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

# Levitra

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## Products Affected

- Levitra

<b>ST Criteria</b>	Documented step through CIALIS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Levocetirizine Dihydrochloride

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## Products Affected

- Levocetirizine Dihydrochloride ORAL  
TABLET

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

# Levonest

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## Products Affected

- Levonest

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

# Levonorgest-Eth Estrad 91-Day

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## Products Affected

- Levonorgest-Eth Estrad 91-Day ORAL  
TABLET 0.15-0.03 MG, 0.1-0.02 & 0.01  
MG

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

# Levonorgestrel-Ethinyl Estrad

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## Products Affected

- Levonorgestrel-Ethinyl Estrad ORAL  
TABLET 0.15-30 MG-MCG

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

## Levora 0.15/30 (28)

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### Products Affected

- Levora 0.15/30 (28)

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

# Lexapro

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## Products Affected

- Lexapro ORAL SOLUTION

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

# Lexapro

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## Products Affected

- Lexapro ORAL TABLET 20 MG, 5 MG

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

# Lexapro

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## Products Affected

- Lexapro ORAL TABLET 10 MG

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



# Lialda

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## Products Affected

- Lialda

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

# Liberty Blood Glucose Meter

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## Products Affected

- Liberty Blood Glucose Meter

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Liberty Blood Glucose Monitor

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## Products Affected

- Liberty Blood Glucose Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Liberty Next Generation Test

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## Products Affected

- Liberty Next Generation Test

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

# Liberty Nxt Generation Monitor

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## Products Affected

- Liberty Nxt Generation Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Liberty Test

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## Products Affected

- Liberty Test

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

# Lidex

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## Products Affected

- Lidex

<b>ST Criteria</b>	Documented step through TWO VERY HIGH POTENCY TOPICAL STEROIDS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lidocaine

## Products Affected

- Lidocaine EXTERNAL OINTMENT

PA Criteria	Criteria Details
<b>Covered Uses</b>	***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.
<b>Exclusion Criteria</b>	Documentation of any of the following: Planned area of application includes non-intact skin, sensitivity to amide-type local anesthetics or any other component of the product, planned use on large surface area of the body as this can lead to increased toxicity, planned area of application includes severely traumatized skin (e.g., mucosal or skin abrasion, eczema, burns), the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), or if the product will be compounded with other products that would alter the total dose/dosage form being administered
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months



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

# Lidocaine-Prilocaine

## Products Affected

- Lidocaine-Prilocaine EXTERNAL CREAM

PA Criteria	Criteria Details
<b>Covered Uses</b>	***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 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
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	*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.

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

<b>QL Criteria</b>	30 GM Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lindane

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## Products Affected

- Lindane EXTERNAL LOTION

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

# Linezolid

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## Products Affected

- Linezolid ORAL SUSPENSION  
RECONSTITUTED

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

# Linezolid

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## Products Affected

- Linezolid ORAL TABLET

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

# Linzess

---

## Products Affected

- Linzess

<b>ST Criteria</b>	Documented step through LACTULOSE AND AMITIZA
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lipitor

---

## Products Affected

- Lipitor

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



# Lipofen

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## Products Affected

- Lipofen

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

# Liptruzet

---

## Products Affected

- Liptruzet

<b>ST Criteria</b>	A documented step through one generic statin medication (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) and Zetia
<b>QL Criteria</b>	1 TAB Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Livalo

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## Products Affected

- Livalo

<b>ST Criteria</b>	A documented step through two generic statin medications (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lo Loestrin Fe

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## Products Affected

- Lo Loestrin Fe

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

## Loestrin 1.5/30 (21)

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### Products Affected

- Loestrin 1.5/30 (21)

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

## Loestrin 1/20 (21)

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### Products Affected

- Loestrin 1/20 (21)

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

# Loestrin Fe 1.5/30

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## Products Affected

- Loestrin Fe 1.5/30

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

# Loestrin Fe 1/20

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## Products Affected

- Loestrin Fe 1/20

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



# Lofibra

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## Products Affected

- Lofibra

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

# Lofibra

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## Products Affected

- Lofibra

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

# Lomedia 24 FE

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## Products Affected

- Lomedia 24 FE

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

# Lonsurf

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## Products Affected

- Lonsurf ORAL TABLET 15-6.14 MG

<b>QL Criteria</b>	100 tablets Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lonsurf

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## Products Affected

- Lonsurf ORAL TABLET 20-8.19 MG

<b>QL Criteria</b>	80 tablets Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Loryna

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## Products Affected

- Loryna

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

# Losartan Potassium

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## Products Affected

- Losartan Potassium ORAL TABLET 50 MG, 25 MG

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

# LoSeasonique

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## Products Affected

- LoSeasonique

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



# Lotronex

## Products Affected

- Lotronex

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe diarrhea-predominant irritable bowel syndrome (IBS)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient is female, and has a documented diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) including one or more of the following: frequent and severe abdominal pain/discomfort, frequent urgency or fecal incontinence or disability or restriction of daily activities due to IBS, AND patient has chronic IBS symptoms generally lasting 6 months or longer, AND anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented trial of 2 alternatives: diphenoxylate/atropine, loperamide
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lovastatin

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## Products Affected

- Lovastatin

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

# Lovaza

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## Products Affected

- Lovaza

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

# Lovenox

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## Products Affected

- Lovenox

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

# Low-Ogestrel

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## Products Affected

- Low-Ogestrel

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

# Lumigan

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## Products Affected

- Lumigan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	open-angle glaucoma, ocular hypertension
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of glaucoma or ocular hypertension
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one week of latanoprost and one week of Travatan Z
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lumizyme

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## Products Affected

- Lumizyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lunesta

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## Products Affected

- Lunesta

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



# Lutera

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## Products Affected

- Lutera

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

# Lynparza

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## Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	480 EA Per 30 Days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lysteda

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## Products Affected

- Lysteda

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

# Lyza

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## Products Affected

- Lyza

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

# Makena

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## Products Affected

- Makena

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/hydroxyprogesterone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/hydroxyprogesterone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Maprotiline HCl

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## Products Affected

- Maprotiline HCl

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

# Marinol

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## Products Affected

- Marinol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 CAPS Per 1 Day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Marlissa

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## Products Affected

- Marlissa

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



# Matzim LA

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## Products Affected

- Matzim LA ORAL TABLET EXTENDED  
RELEASE 24 HR\* 300 MG, 180 MG, 360  
MG

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

# Matzim LA

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## Products Affected

- Matzim LA ORAL TABLET EXTENDED  
RELEASE 24 HR\* 240 MG

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

# Maxalt

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## Products Affected

- Maxalt

<b>QL Criteria</b>	12 tablets Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Maxalt-MLT

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## Products Affected

- Maxalt-MLT

<b>QL Criteria</b>	12 tablets Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Maxima Blood Glucose Test

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## Products Affected

- Maxima Blood Glucose Test

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

# MedroxyPROGESTERone Acetate

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## Products Affected

- MedroxyPROGESTERone Acetate  
INTRAMUSCULAR\* SUSPENSION

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

# Meijer Blood Glucose

## Products Affected

- Meijer Blood Glucose

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Meijer Blood Glucose Test

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## Products Affected

- Meijer Blood Glucose Test

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



# Meijer Premium Blood Glucose

## Products Affected

- Meijer Premium Blood Glucose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Meijer Premium Glucose Test

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## Products Affected

- Meijer Premium Glucose Test

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

# Mekinist

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## Products Affected

- Mekinist

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Memantine HCl

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## Products Affected

- Memantine HCl ORAL TABLET 5 MG,  
10 MG

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

# Memantine HCl

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## Products Affected

- Memantine HCl ORAL TABLET 5 (28)-10  
(21) MG

<b>QL Criteria</b>	1.75 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Menopur

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## Products Affected

- Menopur

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Menostar

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## Products Affected

- Menostar

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

# Mesalamine

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## Products Affected

- Mesalamine ORAL

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



# Metadate CD

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## Products Affected

- Metadate CD ORAL CAPSULE  
EXTENDED RELEASE\* 40 MG, 10 MG,  
60 MG

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

# Metadate CD

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## Products Affected

- Metadate CD ORAL CAPSULE  
EXTENDED RELEASE\* 50 MG

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

# Metadate CD

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## Products Affected

- Metadate CD ORAL CAPSULE  
EXTENDED RELEASE\* 20 MG

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

# Metadate CD

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## Products Affected

- Metadate CD ORAL CAPSULE  
EXTENDED RELEASE\* 30 MG

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

# Metadate ER

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## Products Affected

- Metadate ER ORAL TABLET  
EXTENDEDRELEASE\* 20 MG

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

# Methadone HCl

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## Products Affected

- Methadone HCl ORAL SOLUTION 5 MG/5ML
- Methadone HCl ORAL CONCENTRATE

<b>QL Criteria</b>	60 mg Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Methadone HCl

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## Products Affected

- Methadone HCl ORAL TABLET

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

# Methadone HCl

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## Products Affected

- Methadone HCl ORAL SOLUTION 10 MG/5ML

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



# Methadose

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## Products Affected

- Methadose ORAL TABLET SOLUBLE

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 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), Narcolepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of ADHD or Narcolepsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Methylin

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## Products Affected

- Methylin ORAL SOLUTION 5 MG/5ML

<b>QL Criteria</b>	60 soln Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Methylin

## Products Affected

- Methylin ORAL TABLET CHEWABLE

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of ADHD or Narcolepsy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	6 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Methylin

---

## Products Affected

- Methylin ORAL SOLUTION 10 MG/5ML

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

# Methylphenidate HCl

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## Products Affected

- Methylphenidate HCl ORAL TABLET

<b>QL Criteria</b>	6 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

<b>QL Criteria</b>	60 milliliters Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

<b>QL Criteria</b>	30 milliliters Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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 HR\* 36 MG

<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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  
EXTENDEDRELEASE\* 10 MG, 20 MG

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

# Methylphenidate HCl ER

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## Products Affected

- Methylphenidate HCl ER ORAL TABLET  
EXTENDEDRELEASE\* 27 MG, 18 MG,  
54 MG

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

# Methylphenidate HCl ER

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## Products Affected

- Methylphenidate HCl ER ORAL TABLET  
EXTENDEDRELEASE\* 36 MG

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

# Methylphenidate HCl ER (CD)

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## Products Affected

- Methylphenidate HCl ER (CD)

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

# Methylphenidate HCl ER (LA)

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## Products Affected

- Methylphenidate HCl ER (LA) ORAL  
CAPSULE EXTENDED RELEASE 24  
HOUR 40 MG, 20 MG

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

# Methylphenidate HCl ER (LA)

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## Products Affected

- Methylphenidate HCl ER (LA) ORAL  
CAPSULE EXTENDED RELEASE 24  
HOUR 30 MG

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

# Metoprolol Succinate ER

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## Products Affected

- Metoprolol Succinate ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 200 MG

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



# Metoprolol Succinate ER

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## Products Affected

- Metoprolol Succinate ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 100 MG,  
50 MG

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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 HR\* 25 MG

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

# Mevacor

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## Products Affected

- Mevacor ORAL TABLET 40 MG

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

# Micardis

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## Products Affected

- Micardis

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

# Micardis HCT

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## Products Affected

- Micardis HCT

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

# Microdot Test

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## Products Affected

- Microdot Test

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

# Microgestin 1.5/30

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## Products Affected

- Microgestin 1.5/30

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

# Microgestin 1/20

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## Products Affected

- Microgestin 1/20

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



# Microgestin FE 1.5/30

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## Products Affected

- Microgestin FE 1.5/30

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

# Microgestin FE 1/20

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## Products Affected

- Microgestin FE 1/20

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

# Mimvey

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## Products Affected

- Mimvey

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

# Minivelle

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## Products Affected

- Minivelle

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

# Mirapex ER

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## Products Affected

- Mirapex ER

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

# Mircera

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## Products Affected

- Mircera INJECTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Mircette

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## Products Affected

- Mircette

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

# Mirena (52 MG)

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## Products Affected

- Mirena (52 MG)

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



# Mirtazapine

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## Products Affected

- Mirtazapine ORAL

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

# Mitigare

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## Products Affected

- Mitigare

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

# Modafinil

## Products Affected

- Modafinil ORAL TABLET 100 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 Day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Modafinil

## Products Affected

- Modafinil ORAL TABLET 200 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 Day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Modicon (28)

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## Products Affected

- Modicon (28)

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

# Monoclalte-P

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## Products Affected

- Monoclalte-P

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Mono-Linyah

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## Products Affected

- Mono-Linyah

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

# MonoNessa

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## Products Affected

- MonoNessa

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

# Mononine

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## Products Affected

- Mononine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Monovisc

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## Products Affected

- Monovisc

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Montelukast Sodium

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## Products Affected

- Montelukast Sodium ORAL

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

# Montelukast Sodium

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## Products Affected

- Montelukast Sodium ORAL

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

# Morphine Sulfate ER

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## Products Affected

- Morphine Sulfate ER ORAL TABLET EXTENDEDRELEASE\* 30 MG, 60 MG, 100 MG
- Morphine Sulfate ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR

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

# Morphine Sulfate ER

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## Products Affected

- Morphine Sulfate ER ORAL TABLET  
EXTENDEDRELEASE\* 15 MG, 200 MG

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



# Morphine Sulfate ER Beads

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## Products Affected

- Morphine Sulfate ER Beads

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

# MS Contin

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## Products Affected

- MS Contin ORAL TABLET  
EXTENDEDRELEASE\*

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

# Multaq

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## Products Affected

- Multaq

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

# Myalept

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## Products Affected

- Myalept

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Myalept.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Myalept.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	0.5 VIAL Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# MyGlucoHealth Test

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## Products Affected

- MyGlucoHealth Test

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

# Myorisan

## Products Affected

- Myorisan ORAL CAPSULE 10 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: Patient requires more than 2 capsules per day to reach the appropriate dose for weight, and this is the members FIRST course of therapy or member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month holiday), and member has recieved a cumulative dose of less than 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>ST Criteria</b>	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Updated 12/2016

# Myozyme

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## Products Affected

- Myozyme

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Myrbetriq

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## Products Affected

- Myrbetriq

<b>ST Criteria</b>	Documented trial of 1 preferred generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Mytesi

## Products Affected

- Mytesi

PA Criteria	Criteria Details
<b>Covered Uses</b>	Diarrhea
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Covered for adult members who meet the following criteria: (1) Diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month, and (2) Currently taking antiviral therapy with adherence of at least 80%, and (3) Documentation of unsatisfactory effects with, intolerance to, or inability to take at least one anti-motility agent (loperamide, diphenoxylate/atropine, bismuth subsalicylate) or one or more watery bowel movements per day without regular ADM use.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Myzilra

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## Products Affected

- Myzilra

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

# Naglazyme

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## Products Affected

- Naglazyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Namenda

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## Products Affected

- Namenda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Namenda Titration Pak

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## Products Affected

- Namenda Titration Pak

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Namenda XR

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## Products Affected

- Namenda XR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Namzarin

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## Products Affected

- Namzarin ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Naratriptan HCl

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## Products Affected

- Naratriptan HCl

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



# Natazia

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## Products Affected

- Natazia

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

# Natesto

## Products Affected

- Natesto

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>Notes/References</b>	Annual Review: 02/2016

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Natpara

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## Products Affected

- Natpara

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_diasease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_diasease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 ctg Per 28 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Necon 0.5/35 (28)

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### Products Affected

- Necon 0.5/35 (28)

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

## Necon 1/35 (28)

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### Products Affected

- Necon 1/35 (28)

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

## Necon 1/50 (28)

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### Products Affected

- Necon 1/50 (28)

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

## Necon 10/11 (28)

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### Products Affected

- Necon 10/11 (28)

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



# Nesina

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## Products Affected

- Nesina

<b>ST Criteria</b>	A documented step through one month each of Januvia, Janumet, or Janumet XR, and either Onglyza or Kombiglyze XR
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neupro

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## Products Affected

- Neupro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Moderate to severe restless leg syndrome, Parkinson's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of moderate to severe restless leg syndrome or Parkinson's Disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 patch Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neurontin

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## Products Affected

- Neurontin ORAL CAPSULE

<b>QL Criteria</b>	6 cap Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neurontin

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## Products Affected

- Neurontin ORAL TABLET

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

# Neurontin

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## Products Affected

- Neurontin ORAL SOLUTION

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

# Neutek 2Tek Glucose/Pressure

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## Products Affected

- Neutek 2Tek Glucose/Pressure

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

# Neutek 2Tek Test

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## Products Affected

- Neutek 2Tek Test

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

# Nevirapine ER

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## Products Affected

- Nevirapine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 100 MG

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



# Nevirapine ER

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## Products Affected

- Nevirapine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 400 MG

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

# NexAVAR

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## Products Affected

- NexAVAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NexIUM

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## Products Affected

- NexIUM ORAL CAPSULE DELAYED  
RELEASE 40 MG

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

# NexIUM

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## Products Affected

- NexIUM ORAL PACKET

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

# NexIUM 24HR

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## Products Affected

- NexIUM 24HR ORAL TABLET  
DELAYED RELEASE

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

# Nexplanon

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## Products Affected

- Nexplanon

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

# Next Choice One Dose

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## Products Affected

- Next Choice One Dose

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

# Nicoderm CQ

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## Products Affected

- Nicoderm CQ

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



# Nicorelief

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## Products Affected

- Nicorelief MOUTH/THROAT GUM

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

# Nicorette

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## Products Affected

- Nicorette MOUTH/THROAT GUM

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

# Nicotine

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## Products Affected

- Nicotine TRANSDERMAL PATCH 24 HR

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

# Nicotine Step 1

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## Products Affected

- Nicotine Step 1

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

# Nicotine Step 2

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## Products Affected

- Nicotine Step 2

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

# Nicotine Step 3

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## Products Affected

- Nicotine Step 3

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

# Nicotrol

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## Products Affected

- Nicotrol

<b>QL Criteria</b>	3 boxes-504 ctrtg Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicotrol NS

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## Products Affected

- Nicotrol NS

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



# Nifediac CC

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## Products Affected

- Nifediac CC ORAL TABLET  
EXTENDED RELEASE 24 HR\* 60 MG

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

# Nifediac CC

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## Products Affected

- Nifediac CC ORAL TABLET  
EXTENDED RELEASE 24 HR\* 30 MG

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

# Nifedical XL

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## Products Affected

- Nifedical XL ORAL TABLET  
EXTENDED RELEASE 24 HR\* 30 MG

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

# Nifedical XL

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## Products Affected

- Nifedical XL ORAL TABLET  
EXTENDED RELEASE 24 HR\* 60 MG

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

# NIFEdipine ER

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## Products Affected

- NIFEdipine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 30 MG,  
90 MG

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

# NIFEdipine ER

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## Products Affected

- NIFEdipine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 60 MG

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

# NIFEdipine ER Osmotic Release

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## Products Affected

- NIFEdipine ER Osmotic Release ORAL  
TABLET EXTENDED RELEASE 24 HR\*  
90 MG, 30 MG

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

# NIFEdipine ER Osmotic Release

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## Products Affected

- NIFEdipine ER Osmotic Release ORAL  
TABLET EXTENDED RELEASE 24 HR\*  
60 MG

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



# Nikki

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## Products Affected

- Nikki

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

# Ninlaro

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## Products Affected

- Ninlaro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	3 capsules Per 28 days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nisoldipine ER

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## Products Affected

- Nisoldipine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 25.5 MG,  
40 MG, 8.5 MG, 17 MG, 34 MG, 20 MG

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

# Nisoldipine ER

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## Products Affected

- Nisoldipine ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 30 MG

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

# Nitroglycerin

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## Products Affected

- Nitroglycerin TRANSLINGUAL SOLUTION

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

# Nora-BE

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## Products Affected

- Nora-BE

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

# Norditropin FlexPro

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## Products Affected

- Norditropin FlexPro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Norethindrone

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## Products Affected

- Norethindrone ORAL

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



# Norgestimate-Eth Estradiol

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## Products Affected

- Norgestimate-Eth Estradiol ORAL  
TABLET 0.25-35 MG-MCG

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

# Norgestim-Eth Estrad Triphasic

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## Products Affected

- Norgestim-Eth Estrad Triphasic ORAL  
TABLET 0.18/0.215/0.25 MG-35 MCG

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

# Norinyl 1+35 (28)

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## Products Affected

- Norinyl 1+35 (28)

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

# Norinyl 1+50 (28)

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## Products Affected

- Norinyl 1+50 (28)

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

# Norlyroc

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## Products Affected

- Norlyroc

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

# Nor-QD

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## Products Affected

- Nor-QD

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

# Northera

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## Products Affected

- Northera ORAL CAPSULE 200 MG

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

# Northera

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## Products Affected

- Northera ORAL CAPSULE 100 MG

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



# Northera

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## Products Affected

- Northera ORAL CAPSULE 300 MG

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

## Nortrel 0.5/35 (28)

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### Products Affected

- Nortrel 0.5/35 (28)

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

# Nortrel 1/35 (21)

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## Products Affected

- Nortrel 1/35 (21)

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

## Nortrel 1/35 (28)

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### Products Affected

- Nortrel 1/35 (28)

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

# Nortrel 7/7/7

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## Products Affected

- Nortrel 7/7/7

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

# Nova Max Blood Glucose System

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## Products Affected

- Nova Max Blood Glucose System DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nova Max Glucose Test

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## Products Affected

- Nova Max Glucose Test

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

# Novarel

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## Products Affected

- Novarel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Novoeight

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## Products Affected

- Novoeight

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN 70/30

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## Products Affected

- NovoLIN 70/30

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN 70/30 ReliOn

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## Products Affected

- NovoLIN 70/30 ReliOn

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN N

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## Products Affected

- NovoLIN N

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN N ReliOn

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## Products Affected

- NovoLIN N ReliOn

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN R

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## Products Affected

- NovoLIN R

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN R ReliOn

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## Products Affected

- NovoLIN R ReliOn

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLOG

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## Products Affected

- NovoLOG

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# NovoLOG FlexPen

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## Products Affected

- NovoLOG FlexPen SUBCUTANEOUS\*

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLOG Mix 70/30

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## Products Affected

- NovoLOG Mix 70/30

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLOG Mix 70/30 FlexPen

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## Products Affected

- NovoLOG Mix 70/30 FlexPen  
SUBCUTANEOUS\*

<b>ST Criteria</b>	A documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLOG PenFill

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## Products Affected

- NovoLOG PenFill SUBCUTANEOUS\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 or Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Type 1 or Type 2 Diabetes Mellitus
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy
<b>ST Criteria</b>	Documented trial of one month of one preferred alternative rapid-acting insulin (Humulin or Humalog)
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoSeven RT

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## Products Affected

- NovoSeven RT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Noxafil

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## Products Affected

- Noxafil ORAL TABLET DELAYED  
RELEASE

<b>QL Criteria</b>	93 TBEC Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nplate

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## Products Affected

- Nplate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nucala

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## Products Affected

- Nucala

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/RESP/Interleukin%20Antagonist.html">http://www.aetna.com/products/rxnonmedicare/data/2016/RESP/Interleukin%20Antagonist.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 injection Per 28 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Nucynta

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## Products Affected

- Nucynta

<b>ST Criteria</b>	Documented step through TWO of the following: MORPHINE, OXYCODONE, HYDROMORPHONE
<b>QL Criteria</b>	6 tablets Per 1 day
<b>Notes/ References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nucynta ER

## Products Affected

- Nucynta ER

PA Criteria	Criteria Details
<b>Covered Uses</b>	(1)Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment, (2)Diabetic peripheral neuropathy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic Pain or Diabetic peripheral neuropathy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	Documented step through one month of 2 preferred alternatives. FOR PAIN, qualified alternatives include Butrans, Hysingla ER, and Oxycontin. FOR DIABETIC PERIPHERAL NEUROPATHY, qualified alternatives include Cymbalta and Lyrica.
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nuedexta

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## Products Affected

- Nuedexta

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

# Nuplazid

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## Products Affected

- Nuplazid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/Nuplazid.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/Nuplazid.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nutropin AQ NuSpin 10

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## Products Affected

- Nutropin AQ NuSpin 10

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nutropin AQ NuSpin 20

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## Products Affected

- Nutropin AQ NuSpin 20

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nutropin AQ NuSpin 5

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## Products Affected

- Nutropin AQ NuSpin 5

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NuvaRing

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## Products Affected

- NuvaRing

<b>QL Criteria</b>	1 ring Per 28 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Nuvigil

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nuvigil

## Products Affected

- Nuvigil ORAL TABLET 50 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 Day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nuwiq

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## Products Affected

- Nuwiq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nymalize

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## Products Affected

- Nymalize

<b>QL Criteria</b>	135.2 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ocaliva

## Products Affected

- Ocaliva ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/Primary_Biliary_Cholangitis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/Primary_Biliary_Cholangitis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/Primary_Biliary_Cholangitis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/Primary_Biliary_Cholangitis.html</a>
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ocella

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## Products Affected

- Ocella

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



# Octagam

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## Products Affected

- Octagam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Odefsey

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## Products Affected

- Odefsey

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

# Odomzo

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## Products Affected

- Odomzo

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

# Ofev

## Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Idiopathic_Pulmonary_Fibrosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Idiopathic_Pulmonary_Fibrosis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ogestrel

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## Products Affected

- Ogestrel

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

# OLANZapine

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## Products Affected

- OLANZapine ORAL TABLET 5 MG, 7.5 MG, 10 MG, 15 MG, 20 MG
- OLANZapine ORAL TABLET DISPERSIBLE

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

# OLANZapine

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## Products Affected

- OLANZapine ORAL TABLET 2.5 MG

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

# OLANZapine-FLUoxetine HCl

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## Products Affected

- OLANZapine-FLUoxetine HCl

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



# Oleptro

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## Products Affected

- Oleptro

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

# Olysio

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## Products Affected

- Olysio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 CAPS Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Omega-3-acid Ethyl Esters

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## Products Affected

- Omega-3-acid Ethyl Esters

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

# Omnaris

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## Products Affected

- Omnaris

<b>ST Criteria</b>	Trial of 2 weeks each of 2 of the following: Flonase or Nasalide or Nasacort 24HR OTC, and Nasonex
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Omnitrope

## Products Affected

- Omnitrope SUBCUTANEOUS\*  
SOLUTION RECONSTITUTED
- Omnitrope SUBCUTANEOUS\*  
SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthormone.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# On Call Plus Blood Glucose

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## Products Affected

- On Call Plus Blood Glucose

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

# On Call Vivid Blood Glucose

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## Products Affected

- On Call Vivid Blood Glucose

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

# Ondansetron

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## Products Affected

- Ondansetron

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



# Ondansetron HCl

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## Products Affected

- Ondansetron HCl ORAL TABLET 4 MG,  
24 MG

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

# Ondansetron HCl

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## Products Affected

- Ondansetron HCl ORAL TABLET 8 MG

<b>QL Criteria</b>	60 tablets Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ondansetron HCl

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## Products Affected

- Ondansetron HCl ORAL SOLUTION

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

# OneTouch Ultra 2

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## Products Affected

- OneTouch Ultra 2

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

# OneTouch Ultra Blue

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## Products Affected

- OneTouch Ultra Blue

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

# OneTouch Ultra Mini

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## Products Affected

- OneTouch Ultra Mini

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

# OneTouch Verio

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## Products Affected

- OneTouch Verio IN VITRO STRIP

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

# OneTouch Verio IQ System

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## Products Affected

- OneTouch Verio IQ System

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



# Onexton

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## Products Affected

- Onexton

<b>ST Criteria</b>	Documentation of one month of the preferred generic alternative, benzoyl peroxide/clindamycin phosphate gel or benzoyl peroxide/erythromycin gel
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onfi

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## Products Affected

- Onfi ORAL TABLET 20 MG, 10 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onfi

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## Products Affected

- Onfi ORAL TABLET 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onfi

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## Products Affected

- Onfi ORAL SUSPENSION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onglyza

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## Products Affected

- Onglyza

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

# Onsolis

## Products Affected

- Onsolis

PA Criteria	Criteria Details
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	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))

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

<b>ST Criteria</b>	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onzetra Xsail

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## Products Affected

- Onzetra Xsail

<b>ST Criteria</b>	A documented step through sumatriptan nasal spray
<b>QL Criteria</b>	1 kit Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Opana ER

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## Products Affected

- Opana ER ORAL TABLET EXTENDED  
RELEASE 12 HR\* 20 MG, 5 MG, 30 MG,  
10 MG, 40 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Opana ER

## Products Affected

- Opana ER ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	A documented step through one month each of two preferred alternatives which include Butrans, Hysingla ER, and Oxycontin
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Opsumit

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## Products Affected

- Opsumit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oramorph SR

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## Products Affected

- Oramorph SR ORAL TABLET  
EXTENDEDRELEASE\*

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

# Oravig

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## Products Affected

- Oravig

<b>QL Criteria</b>	14 tablets Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orencia

## Products Affected

- Orencia SUBCUTANEOUS\*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html</a>
QL Criteria	4 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orencia

## Products Affected

- Orencia INTRAVENOUS\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orencia ClickJect

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## Products Affected

- Orencia ClickJect

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html</a>
<b>QL Criteria</b>	4 syringes Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Orenitram

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## Products Affected

- Orenitram

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orkambi

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## Products Affected

- Orkambi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orkambi

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## Products Affected

- Orkambi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orsythia

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## Products Affected

- Orsythia

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

# Ortho Diaphragm All-Flex

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## Products Affected

- Ortho Diaphragm All-Flex VAGINAL  
DIAPHRAGM 70 MM

<b>QL Criteria</b>	1 device Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ortho Micronor

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## Products Affected

- Ortho Micronor

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

## Ortho Tri-Cyclen (28)

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### Products Affected

- Ortho Tri-Cyclen (28)

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

# Ortho Tri-Cyclen Lo

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## Products Affected

- Ortho Tri-Cyclen Lo

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



## Ortho-Cept (28)

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### Products Affected

- Ortho-Cept (28)

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

# Ortho-Cyclen (28)

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## Products Affected

- Ortho-Cyclen (28)

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

## Ortho-Novum 1/35 (28)

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### Products Affected

- Ortho-Novum 1/35 (28)

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

## Ortho-Novum 7/7/7 (28)

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### Products Affected

- Ortho-Novum 7/7/7 (28)

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

# OrthoVisc

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## Products Affected

- OrthoVisc INTRA-ARTICULAR\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oseni

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## Products Affected

- Oseni

<b>ST Criteria</b>	A documented step through one month each of Invokana/Invokamet and either Januvia/Janumet or Onglyza/Kombiglyze
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Osphena

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## Products Affected

- Osphena

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

# Otezla

## Products Affected

- Otezla ORAL 10 & 20 & 30 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html</a>
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Otezla

## Products Affected

- Otezla ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html</a>
QL Criteria	2 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Ovcon-35 (28)

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### Products Affected

- Ovcon-35 (28)

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

# Ovidrel

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## Products Affected

- Ovidrel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxtellar XR

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## Products Affected

- Oxtellar XR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 150 MG, 300 MG

<b>ST Criteria</b>	Documented trial and failure of 1 month of oxcarbazepine
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxtellar XR

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## Products Affected

- Oxtellar XR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 600 MG

<b>ST Criteria</b>	Documented trial and failure of 1 month of oxcarbazepine
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxybutynin Chloride

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## Products Affected

- Oxybutynin Chloride ORAL TABLET

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

# OxyCODONE HCl ER

## Products Affected

- OxyCODONE HCl ER ORAL 10 MG, 20 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented step through one month each of two preferred alternatives which include Butrans, Hysingla ER, and Oxycontin
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxycodone-Ibuprofen

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## Products Affected

- Oxycodone-Ibuprofen

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



# OxyCONTIN

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## Products Affected

- OxyCONTIN ORAL

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

# Oxymorphone HCl ER

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## Products Affected

- Oxymorphone HCl ER

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

# Paliperidone ER

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## Products Affected

- Paliperidone ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 1.5 MG,  
6 MG, 3 MG

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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 HR\* 9 MG

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

# Pamidronate Disodium

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## Products Affected

- Pamidronate Disodium

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pancreaze

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## Products Affected

- Pancreaze ORAL CAPSULE DELAYED  
RELEASE PARTICLES 16800-40000  
UNIT, 4200-10000 UNIT, 10500-25000  
UNIT, 21000-37000 UNIT

<b>ST Criteria</b>	Documented step through CREON AND ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Paragard Intrauterine Copper

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## Products Affected

- Paragard Intrauterine Copper

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

# Paricalcitol

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## Products Affected

- Paricalcitol ORAL

<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# PARoxetine HCl ER

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## Products Affected

- PARoxetine HCl ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 37.5 MG,  
12.5 MG

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

# PARoxetine HCl ER

---

## Products Affected

- PARoxetine HCl ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 25 MG

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

# Paxil

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## Products Affected

- Paxil ORAL TABLET 40 MG, 30 MG

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

# Paxil

---

## Products Affected

- Paxil ORAL TABLET 10 MG, 20 MG

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

# Paxil

---

## Products Affected

- Paxil ORAL SUSPENSION

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

# Paxil CR

---

## Products Affected

- Paxil CR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 12.5 MG

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



# Paxil CR

---

## Products Affected

- Paxil CR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 25 MG

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

# Paxil CR

---

## Products Affected

- Paxil CR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 37.5 MG

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

# PEG 3350/Electrolytes

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## Products Affected

- PEG 3350/Electrolytes

<b>QL Criteria</b>	4 liters Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PEG-3350/Electrolytes

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## Products Affected

- PEG-3350/Electrolytes

<b>QL Criteria</b>	4 liters Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pegasys

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## Products Affected

- Pegasys SUBCUTANEOUS\* SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pegasys ProClick

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## Products Affected

- Pegasys ProClick

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PegIntron

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## Products Affected

- PegIntron

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Peg-Intron

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## Products Affected

- Peg-Intron

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Peg-Intron Redipen

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## Products Affected

- Peg-Intron Redipen SUBCUTANEOUS\*  
KIT 80 MCG/0.5ML, 150 MCG/0.5ML, 50  
MCG/0.5ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Peg-Intron Redipen Pak 4

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## Products Affected

- Peg-Intron Redipen Pak 4  
SUBCUTANEOUS\* KIT 120  
MCG/0.5ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pennsaid

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## Products Affected

- Pennsaid TRANSDERMAL SOLUTION 2  
%

<b>ST Criteria</b>	Documented Trial of 1 month of Voltaren Gel
<b>QL Criteria</b>	4 ml Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pentasa

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## Products Affected

- Pentasa ORAL CAPSULE EXTENDED RELEASE\* 500 MG

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

# Pentasa

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## Products Affected

- Pentasa ORAL CAPSULE EXTENDED  
RELEASE\* 250 MG

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

# Perforomist

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## Products Affected

- Perforomist

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic Obstructive Pulmonary Disorder (COPD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of one month of Serevent
<b>QL Criteria</b>	4 milliliters Per 1 day
<b>Notes/References</b>	Annual Review: 07/2016
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pertzye

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## Products Affected

- Pertzye

<b>ST Criteria</b>	Documented step through CREON AND ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pharmacist Choice Autocode

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## Products Affected

- Pharmacist Choice Autocode

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



# Philith

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## Products Affected

- Philith

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

# Picato

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## Products Affected

- Picato EXTERNAL GEL 0.05 %

<b>QL Criteria</b>	2 unit dose tubes Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Picato

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## Products Affected

- Picato EXTERNAL GEL 0.015 %

<b>QL Criteria</b>	3 unit dose tubes Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pioglitazone HCl

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## Products Affected

- Pioglitazone HCl

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

# Pioglitazone HCl-Glimepiride

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## Products Affected

- Pioglitazone HCl-Glimepiride

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

# Pioglitazone HCl-Metformin HCl

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## Products Affected

- Pioglitazone HCl-Metformin HCl

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

# Plan B One-Step

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## Products Affected

- Plan B One-Step

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

# Plavix

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## Products Affected

- Plavix ORAL TABLET 75 MG

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



# Plegridy

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## Products Affected

- Plegridy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 inj Per 28 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Plegridy Starter Pack

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## Products Affected

- Plegridy Starter Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 inj Per 28 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PocketChem EZ Test

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## Products Affected

- PocketChem EZ Test

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

# Pomalyst

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## Products Affected

- Pomalyst

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Portia-28

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## Products Affected

- Portia-28

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

# Potiga

## Products Affected

- Potiga ORAL TABLET 200 MG, 300 MG, 400 MG

PA Criteria	Criteria Details
Covered Uses	partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Potiga

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## Products Affected

- Potiga ORAL TABLET 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	partial-onset seizures
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	6 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pradaxa

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## Products Affected

- Pradaxa

<b>ST Criteria</b>	Documented step through ELIQUIS and XARELTO
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Praluent

## Products Affected

- Praluent

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
<b>QL Criteria</b>	2 syringes Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pramipexole Dihydrochloride ER

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## Products Affected

- Pramipexole Dihydrochloride ER

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

# Pramipexole Dihydrochloride ER

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## Products Affected

- Pramipexole Dihydrochloride ER

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

# PrandiMet

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## Products Affected

- PrandiMet

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

# Pravachol

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## Products Affected

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

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

# Pravastatin Sodium

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## Products Affected

- Pravastatin Sodium

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

# Precision PCx

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## Products Affected

- Precision PCx

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

# Precision Xtra

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## Products Affected

- Precision Xtra DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Precision Xtra Blood Glucose

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## Products Affected

- Precision Xtra Blood Glucose

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

# Precision Xtra Monitor

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## Products Affected

- Precision Xtra Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prefest

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## Products Affected

- Prefest

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

# Pregnyl

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## Products Affected

- Pregnyl

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Premarin

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## Products Affected

- Premarin ORAL

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

# Premphase

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## Products Affected

- Premphase

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

# Prempro

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## Products Affected

- Prempro

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

# Prevacid

## Products Affected

- Prevacid ORAL CAPSULE DELAYED  
RELEASE 30 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Prevacid 24HR

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## Products Affected

- Prevacid 24HR

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

# Prevacid SoluTab

## Products Affected

- Prevacid SoluTab

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Updated 12/2016

# Previfem

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## Products Affected

- Previfem

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

# Prezista

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## Products Affected

- Prezista ORAL TABLET 600 MG, 150 MG, 75 MG

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

# Prezista

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## Products Affected

- Prezista ORAL TABLET 800 MG

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

# Prezista

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## Products Affected

- Prezista ORAL SUSPENSION

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

# PriLOSEC

## Products Affected

- PriLOSEC ORAL PACKET

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pristiq

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## Products Affected

- Pristiq ORAL TABLET EXTENDED  
RELEASE 24 HR\* 100 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Pristiq

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## Products Affected

- Pristiq ORAL TABLET EXTENDED  
RELEASE 24 HR\* 25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Privigen

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## Products Affected

- Privigen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Procardia XL

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## Products Affected

- Procardia XL ORAL TABLET  
EXTENDED RELEASE 24 HR\* 90 MG,  
60 MG

<b>QL Criteria</b>	2 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Procardia XL

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## Products Affected

- Procardia XL ORAL TABLET  
EXTENDED RELEASE 24 HR\* 30 MG

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

# ProCentra

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## Products Affected

- ProCentra

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of ADHD or Narcolepsy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	40 milliliters Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Procrit

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## Products Affected

- Procrit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Procysbi

## Products Affected

- Procysbi ORAL CAPSULE DELAYED  
RELEASE 75 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	25 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Procysbi

## Products Affected

- Procysbi ORAL CAPSULE DELAYED  
RELEASE 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Prodigy AutoCode Blood Glucose

## Products Affected

- Prodigy AutoCode Blood Glucose KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prodigy AutoCode Blood Glucose

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## Products Affected

- Prodigy AutoCode Blood Glucose  
DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prodigy No Coding Blood Gluc

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## Products Affected

- Prodigy No Coding Blood Gluc

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

# Profilnine

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## Products Affected

- Profilnine INTRAVENOUS\* SOLUTION  
RECONSTITUTED 1000 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Profilnine SD

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## Products Affected

- Profilnine SD INTRAVENOUS\*  
SOLUTION RECONSTITUTED 500  
UNIT, 1500 UNIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Progesterone Micronized

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## Products Affected

- Progesterone Micronized ORAL

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

# Prolia

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## Products Affected

- Prolia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promacta

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## Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html</a>
Exclusion 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 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Promacta

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## Products Affected

- Promacta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prometrium

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## Products Affected

- Prometrium

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

# Propafenone HCl ER

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## Products Affected

- Propafenone HCl ER

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

# Protopic

## Products Affected

- Protopic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Atopic dermatitis, Vitiligo
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. FOR PROTOPIC 0.03%: A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required) or a documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or child 2 years of age or older and either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition

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Updated 12/2016

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Proventil HFA

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## Products Affected

- Proventil HFA

<b>ST Criteria</b>	Documented step through one week each of VENTOLIN HFA AND PROAIR
<b>Notes/ References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: November 09, 2016 Quantity Limits: August 25, 2015

# Provigil

## Products Affected

- Provigil

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tabs Per 1 Day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Provigil

## Products Affected

- Provigil

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 Day

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PROzac

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## Products Affected

- PROzac ORAL CAPSULE 20 MG

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

# PROzac

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## Products Affected

- PROzac ORAL CAPSULE 40 MG

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

# PROzac

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## Products Affected

- PROzac ORAL CAPSULE 10 MG

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

# PROzac Weekly

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## Products Affected

- PROzac Weekly

<b>QL Criteria</b>	0.15 CAPS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pulmicort

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## Products Affected

- Pulmicort

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Asthma
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For ages 5-8 documented inability to use metered dose inhalers
<b>Age Restrictions</b>	Less than 8 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Up to the age of 8
<b>Other Criteria</b>	No prior authorization required for children 1-4 years of age. Medical Exception for Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
<b>Notes/References</b>	Annual Review: 07/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 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	3 years
Other Criteria	Step Therapy. Medical Exception for Flovent Diskus and Flovent HFA: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Documented step through one month of ASMANEX AND QVAR
QL Criteria	1 inhaler Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Pulmozyme

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## Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ampules Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Purixan

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## Products Affected

- Purixan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	3.5 ML Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Qbrelis

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## Products Affected

- Qbrelis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Hypertension, Heart Failure, Myocardial Infarction
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of hypertension (Approved only for ages 6 and older), Heart failure, or Myocardial Infarction AND must have a documented inability to swallow tablets/capsules
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Qnasl

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## Products Affected

- Qnasl

<b>ST Criteria</b>	Trial of 2 weeks each of Nasonex and one of the following: Flonase, Nasalide, or Nasacort 24HR OTC
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Quartette

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## Products Affected

- Quartette

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

# Quasense

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## Products Affected

- Quasense

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

# Qudexy XR

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## Products Affected

- Qudexy XR ORAL 100 MG, 50 MG, 25 MG

<b>ST Criteria</b>	trial of one month of the preferred generic alternative, topiramate
<b>QL Criteria</b>	1 CAPS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Qudexy XR

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## Products Affected

- Qudexy XR ORAL 200 MG, 150 MG

<b>ST Criteria</b>	trial of one month of the preferred generic alternative, topiramate
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# QUetiapine Fumarate

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## Products Affected

- QUetiapine Fumarate ORAL TABLET  
400 MG, 300 MG

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

# QUetiapine Fumarate

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## Products Affected

- QUetiapine Fumarate ORAL TABLET  
100 MG, 50 MG

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

# QUetiapine Fumarate

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## Products Affected

- QUetiapine Fumarate ORAL TABLET  
200 MG

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

# QUetiapine Fumarate

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## Products Affected

- QUetiapine Fumarate ORAL TABLET 25 MG

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

# QuilliChew ER

## Products Affected

- QuilliChew ER ORAL 30 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)
<b>Exclusion Criteria</b>	Documentation of a diagnosis of either adult ADHD or of childhood ADHD onset with history of previous treatment and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment)
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# QuilliChew ER

## Products Affected

- QuilliChew ER ORAL 20 MG, 40 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)
<b>Exclusion Criteria</b>	Documentation of a diagnosis of either adult ADHD or of childhood ADHD onset with history of previous treatment and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment)
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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# Quillivant XR

## Products Affected

- Quillivant XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit disorder, Attention deficit hyperactivity disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of adult ADD or ADHD OR documentation of a diagnosis of childhood ADHD onset with history of previous treatment, and documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through 14 days each of THREE of AMPHETAMINE/DEXTROAMPHETAMINE/ SR, DEXMETHYLPHENIDATE/ SR, DEXTROAMPHETAMINE, METHAMPHETAMINE, METHYLPHENIDATE/ ER/ SR, STRATTERA, OR VYVANSE
<b>QL Criteria</b>	12 milliliters Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# QuiNINE Sulfate

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## Products Affected

- QuiNINE Sulfate ORAL

<b>QL Criteria</b>	42 capsule Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# RA Blood Glucose Monitor

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## Products Affected

- RA Blood Glucose Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RA Nicotine

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## Products Affected

- RA Nicotine TRANSDERMAL

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

# RA TRUEtest Test

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## Products Affected

- RA TRUEtest Test

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

# RABEprazole Sodium

## Products Affected

- RABEprazole Sodium

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ranexa

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## Products Affected

- Ranexa

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

# Ravicti

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## Products Affected

- Ravicti

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	20 bottles Per 30 months
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rayos

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## Products Affected

- Rayos

<b>ST Criteria</b>	Documented step through PREDNISONONE
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Razadyne

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## Products Affected

- Razadyne ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Rebetol

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## Products Affected

- Rebetol ORAL SOLUTION

<b>QL Criteria</b>	5 bottles Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Reclast

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## Products Affected

- Reclast

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_diasease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_diasease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Reclipsen

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## Products Affected

- Reclipsen

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

# Recombinate

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## Products Affected

- Recombinate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rectiv

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## Products Affected

- Rectiv

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

# RefuAH Plus Blood Glucose Test

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## Products Affected

- RefuAH Plus Blood Glucose Test

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

# Relenza Diskhaler

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## Products Affected

- Relenza Diskhaler

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

# ReliOn Prime Monitor

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## Products Affected

- ReliOn Prime Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Relistor

## Products Affected

- Relistor SUBCUTANEOUS\* KIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	0.14 ml Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Relistor

## Products Affected

- Relistor SUBCUTANEOUS\* SOLUTION  
8 MG/0.4ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	0.4 ML Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Relistor

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## Products Affected

- Relistor ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of opioid induced constipation due to non-cancer pain and documented concomitant use of opioid therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	3 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	0.6 ML Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Relpax

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## Products Affected

- Relpax

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

# Remeron

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## Products Affected

- Remeron

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

# Remeron SolTab

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## Products Affected

- Remeron SolTab

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

# Remicade

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## Products Affected

- Remicade

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Remodulin

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## Products Affected

- Remodulin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Repaglinide-Metformin HCl

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## Products Affected

- Repaglinide-Metformin HCl

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

# Repatha

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## Products Affected

- Repatha

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
QL Criteria	2 syringes Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Repatha Pushtronex System

## Products Affected

- Repatha Pushtronex System

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
QL Criteria	1 syringe Per 30 days
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Repatha SureClick

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## Products Affected

- Repatha SureClick

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html</a>
QL Criteria	2 syringes Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Repronex

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## Products Affected

- Repronex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Requip XL

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## Products Affected

- Requip XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 4 MG, 8 MG, 6 MG

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

# Requip XL

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## Products Affected

- Requip XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 12 MG

<b>QL Criteria</b>	2 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Rescula

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## Products Affected

- Rescula

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	open-angle glaucoma, ocular hypertension
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of glaucoma or ocular hypertension
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one week of latanoprost and one week of Travatan Z
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Restoril

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## Products Affected

- Restoril ORAL CAPSULE 22.5 MG, 7.5 MG

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

# Retin-A

## Products Affected

- Retin-A

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Retin-A Micro

## Products Affected

- Retin-A Micro

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Retin-A Micro Pump

## Products Affected

- Retin-A Micro Pump

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Revatio

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## Products Affected

- Revatio ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	3 TABS Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Revatio

## Products Affected

- Revatio INTRAVENOUS\*
- Revatio ORAL SUSPENSION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Reveal Blood Glucose Test

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## Products Affected

- Reveal Blood Glucose Test

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



# Revlimid

## Products Affected

- Revlimid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rexall Blood Glucose Test

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## Products Affected

- Rexall Blood Glucose Test

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

# Rexulti

## Products Affected

- Rexulti

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Schizophrenia
Exclusion Criteria	
Required Medical Information	Documented diagnosis of major depressive disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: Trial of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR SCHIZOPHRENIA: Trial of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 08/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Reyataz

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## Products Affected

- Reyataz ORAL CAPSULE 200 MG

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

# Reyataz

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## Products Affected

- Reyataz ORAL CAPSULE 150 MG, 300 MG

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

# RiaSTAP

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## Products Affected

- RiaSTAP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS100 Blood Glucose

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## Products Affected

- Rightest GS100 Blood Glucose

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

# Rightest GS300 Blood Glucose

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## Products Affected

- Rightest GS300 Blood Glucose

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



# Rightest GS550 Blood Glucose

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## Products Affected

- Rightest GS550 Blood Glucose

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

# Rilutek

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## Products Affected

- Rilutek

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	amyotrophic lateral sclerosis (ALS)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of amyotrophic lateral sclerosis (ALS)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Riluzole

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## Products Affected

- Riluzole

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	amyotrophic lateral sclerosis (ALS)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of amyotrophic lateral sclerosis (ALS)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Risedronate Sodium

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## Products Affected

- Risedronate Sodium ORAL TABLET 35 MG
- Risedronate Sodium ORAL TABLET DELAYED RELEASE

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

# Risedronate Sodium

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## Products Affected

- Risedronate Sodium ORAL TABLET 5 MG, 30 MG

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

# Risedronate Sodium

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## Products Affected

- Risedronate Sodium ORAL TABLET 150 MG

<b>ST Criteria</b>	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
<b>QL Criteria</b>	1 tablet Per 1 month
<b>Notes/ References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL

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## Products Affected

- RisperDAL ORAL TABLET 0.25 MG, 3 MG, 2 MG, 0.5 MG, 1 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	2 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL

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## Products Affected

- RisperDAL ORAL TABLET 4 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	4 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# RisperDAL

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## Products Affected

- RisperDAL ORAL SOLUTION

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

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## Products Affected

- RisperDAL M-TAB ORAL TABLET  
DISPERSIBLE 4 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

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## Products Affected

- RisperDAL M-TAB ORAL TABLET  
DISPERSIBLE 0.5 MG, 2 MG, 1 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	2 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

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## Products Affected

- RisperDAL M-TAB ORAL TABLET  
DISPERSIBLE 4 MG

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

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## Products Affected

- RisperDAL M-TAB ORAL TABLET  
DISPERSIBLE 0.5 MG, 1 MG, 2 MG

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	2 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

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## Products Affected

- RisperDAL M-TAB ORAL TABLET  
DISPERSIBLE 3 MG

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

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## Products Affected

- RisperDAL M-TAB ORAL TABLET  
DISPERSIBLE 3 MG

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperiDONE

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## Products Affected

- RisperiDONE ORAL TABLET DISPERSIBLE 0.5 MG, 1 MG, 2 MG
- RisperiDONE ORAL TABLET 1 MG, 2 MG, 0.25 MG, 0.5 MG

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



# RisperiDONE

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## Products Affected

- RisperiDONE ORAL TABLET DISPERSIBLE 4 MG
- RisperiDONE ORAL TABLET 4 MG

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

# RisperiDONE

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## Products Affected

- RisperiDONE ORAL TABLET 3 MG
- RisperiDONE ORAL TABLET DISPERSIBLE 3 MG

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

# RisperiDONE M-TAB

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## Products Affected

- RisperiDONE M-TAB ORAL TABLET  
DISPERSIBLE 0.5 MG, 2 MG, 1 MG

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

# RisperiDONE M-TAB

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## Products Affected

- RisperiDONE M-TAB ORAL TABLET  
DISPERSIBLE 3 MG

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

# RisperiDONE M-TAB

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## Products Affected

- RisperiDONE M-TAB ORAL TABLET  
DISPERSIBLE 4 MG

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

# Ritalin

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## Products Affected

- Ritalin

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

# Ritalin LA

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## Products Affected

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

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

# Ritalin LA

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## Products Affected

- Ritalin LA ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 30 MG, 10 MG

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



# Ritalin LA

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## Products Affected

- Ritalin LA ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 60 MG

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

# Rivastigmine

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## Products Affected

- Rivastigmine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rivastigmine Tartrate

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## Products Affected

- Rivastigmine Tartrate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Alzheimer's Disease
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
<b>Age Restrictions</b>	less than 40 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rixubis

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## Products Affected

- Rixubis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rizatriptan Benzoate

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## Products Affected

- Rizatriptan Benzoate

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

# ROPINIRole HCl ER

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## Products Affected

- ROPINIRole HCl ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 6 MG, 8  
MG, 2 MG, 4 MG

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

# ROPINIRole HCl ER

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## Products Affected

- ROPINIRole HCl ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 12 MG

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

# Rosuvastatin Calcium

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## Products Affected

- Rosuvastatin Calcium

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



# Rozerem

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## Products Affected

- Rozerem

<b>ST Criteria</b>	Documentation of a trial and failure with Ambien IR (zolpidem tartrate) or Sonata (zalelpon)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ruconest

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## Products Affected

- Ruconest

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rythmol SR

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## Products Affected

- Rythmol SR

<b>QL Criteria</b>	2 CP12 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sabril

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## Products Affected

- Sabril

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

# Sabril

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## Products Affected

- Sabril

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

# Safyral

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## Products Affected

- Safyral

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

# Saizen

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## Products Affected

- Saizen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Samsca

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## Products Affected

- Samsca ORAL TABLET 30 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.htm">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.htm</a> 1
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Samsca

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## Products Affected

- Samsca ORAL TABLET 15 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.htm">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.htm</a> 1
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sancuso

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## Products Affected

- Sancuso

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

# Saphris

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## Products Affected

- Saphris

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Savaysa

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## Products Affected

- Savaysa

<b>ST Criteria</b>	Documented Trial of Eliquis AND Xarelto
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Savella

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## Products Affected

- Savella

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D. Fibromyalgia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of fibromyalgia
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: July 25, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Savella Titration Pack

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## Products Affected

- Savella Titration Pack

<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Seasonique

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## Products Affected

- Seasonique

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

# Seebri Neohaler

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## Products Affected

- Seebri Neohaler

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic Obstructive Pulmonary Disorder (COPD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of 1 month each of Spiriva and Incruse Ellipta
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Selzentry

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## Products Affected

- Selzentry ORAL TABLET 150 MG

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

# Sensipar

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## Products Affected

- Sensipar

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Documented diagnosis of hyperparathyroidism & parathyroid carcinoma or other FDA approved indication
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Serevent Diskus

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## Products Affected

- Serevent Diskus

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

# SEROquel

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## Products Affected

- SEROquel ORAL TABLET 300 MG, 400 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	2 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

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## Products Affected

- SEROquel ORAL TABLET 50 MG, 100 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	3 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

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## Products Affected

- SEROquel ORAL TABLET 200 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	4 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

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## Products Affected

- SEROquel ORAL TABLET 25 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	6 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel XR

## Products Affected

- SEROquel XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 150 MG,  
200 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder, Bipolar Disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Step Therapy
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: Trial of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR SCHIZOPHRENIA: Trial of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# SEROquel XR

## Products Affected

- SEROquel XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 300 MG,  
400 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder, Bipolar Disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Step Therapy
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: Trial of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR SCHIZOPHRENIA: Trial of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Serostim

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## Products Affected

- Serostim SUBCUTANEOUS\* SOLUTION  
RECONSTITUTED 4 MG, 6 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sertraline HCl

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## Products Affected

- Sertraline HCl ORAL CONCENTRATE

<b>QL Criteria</b>	10 ml Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sertraline HCl

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## Products Affected

- Sertraline HCl ORAL TABLET 50 MG

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

# Sertraline HCl

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## Products Affected

- Sertraline HCl ORAL TABLET 100 MG

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

# Sertraline HCl

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## Products Affected

- Sertraline HCl ORAL TABLET 25 MG

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

# Sharobel

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## Products Affected

- Sharobel

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

# Signifor

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## Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Signifor.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Signifor.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 SOLN Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Signifor LAR

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## Products Affected

- Signifor LAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Signifor.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Signifor.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sildenafil Citrate

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## Products Affected

- Sildenafil Citrate ORAL

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

# Simcor

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## Products Affected

- Simcor ORAL TABLET EXTENDED  
RELEASE 24 HR\* 500-20 MG, 750-20  
MG, 1000-20 MG

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

# Simcor

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## Products Affected

- Simcor ORAL TABLET EXTENDED  
RELEASE 24 HR\* 1000-40 MG, 500-40  
MG

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

# Simponi

## Products Affected

- Simponi SUBCUTANEOUS\*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 1 month
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Simponi Aria

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## Products Affected

- Simponi Aria

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi_Aria.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi_Aria.html</a>
Exclusion 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 1 month
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Simvastatin

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## Products Affected

- Simvastatin ORAL

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

# Singular

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## Products Affected

- Singular ORAL PACKET

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



# Sirturo

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## Products Affected

- Sirturo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Multi-drug resistant tuberculosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 years or greater
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>QL Criteria</b>	188 EA Per 365 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Skyla

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## Products Affected

- Skyla

<b>QL Criteria</b>	1 IUD Per 365 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SM Nicotine

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## Products Affected

- SM Nicotine TRANSDERMAL

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

# Smartest Blood Glucose Test

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## Products Affected

- Smartest Blood Glucose Test

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

# Smartest Eject

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## Products Affected

- Smartest Eject

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Smartest Protege

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## Products Affected

- Smartest Protege

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sodium Phenylbutyrate

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## Products Affected

- Sodium Phenylbutyrate ORAL POWDER  
3 GM/TSP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Solia

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## Products Affected

- Solia

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



# Soliris

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## Products Affected

- Soliris

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/soliris.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/soliris.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Solus V2 Test

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## Products Affected

- Solus V2 Test

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

# Somavert

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## Products Affected

- Somavert

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sonata

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## Products Affected

- Sonata ORAL CAPSULE 5 MG

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

# Sonata

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## Products Affected

- Sonata ORAL CAPSULE 10 MG

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

# Soolantra

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## Products Affected

- Soolantra

<b>ST Criteria</b>	A documented trial of one month each of any of the preferred topical generic alternatives, metronidazole OR sulfacetamide sodium with sulfur
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Soriatane

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## Products Affected

- Soriatane ORAL CAPSULE 10 MG, 17.5 MG, 25 MG

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

# Sovaldi

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## Products Affected

- Sovaldi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 TABS Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Spiriva HandiHaler

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## Products Affected

- Spiriva HandiHaler

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

# Spiriva Respimat

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## Products Affected

- Spiriva Respimat

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

# Sporanox

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## Products Affected

- Sporanox ORAL CAPSULE

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

# Sporanox Pulsepak

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## Products Affected

- SporanoX Pulsepak

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

# Sprintec 28

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## Products Affected

- Sprintec 28

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

# Spritam

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## Products Affected

- Spritam

<b>ST Criteria</b>	Documented trial and failure of immediate release levitiracetam tablets
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sprix

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## Products Affected

- Sprix

<b>QL Criteria</b>	5 UD sprays Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sprycel

## Products Affected

- Sprycel ORAL TABLET 50 MG, 20 MG, 80 MG, 70 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sprycel

## Products Affected

- Sprycel ORAL TABLET 100 MG, 140 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sronyx

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## Products Affected

- Sronyx

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

# Staxyn

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## Products Affected

- Staxyn

<b>ST Criteria</b>	Documented step through CIALIS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stelara

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## Products Affected

- Stelara INTRAVENOUS\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Stelara.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Stelara.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 vials Per 30 days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stelara

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## Products Affected

- Stelara SUBCUTANEOUS\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 syringe Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stendra

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## Products Affected

- Stendra

<b>ST Criteria</b>	Documented step through CIALIS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stiolto Respimat

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## Products Affected

- Stiolto Respimat

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

# Stivarga

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## Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Strattera

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## Products Affected

- Strattera

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

# Strensiq

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## Products Affected

- Strensiq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stribild

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## Products Affected

- Stribild

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

# Striverdi Respimat

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## Products Affected

- Striverdi Respimat

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic Obstructive Pulmonary Disorder (COPD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trail of one month of Serevent
<b>Notes/References</b>	Annual Review: 07/2016
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Suboxone

## Products Affected

- Suboxone SUBLINGUAL FILM 4-1 MG, 8-2 MG, 2-0.5 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

PA Criteria	Criteria Details
Other Criteria	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
QL Criteria	3 films Per 1 day
Notes/References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Suboxone

## Products Affected

- Suboxone SUBLINGUAL TABLET  
SUBLINGUAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Suboxone

## Products Affected

- Suboxone SUBLINGUAL FILM 12-3 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>QL Criteria</b>	2 films Per 1 day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Subsys

## Products Affected

- Subsys

PA Criteria	Criteria Details
<b>Covered Uses</b>	For pain due to malignant diagnosis only
<b>Exclusion Criteria</b>	Use in non-malignant pain
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	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))

<b>ST Criteria</b>	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
<b>QL Criteria</b>	8 sprays Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sular

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## Products Affected

- Sular ORAL TABLET EXTENDED  
RELEASE 24 HR\* 17 MG, 8.5 MG, 34  
MG

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

# SulfaSALazine

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## Products Affected

- SulfaSALazine ORAL

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

# Sulfazine

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## Products Affected

- Sulfazine

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

# Sulfazine EC

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## Products Affected

- Sulfazine EC

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



# SUMAtriptan

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## Products Affected

- SUMAtriptan NASAL

<b>QL Criteria</b>	3 nasal sprays Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SUMAtriptan Succinate

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## Products Affected

- SUMAtriptan Succinate  
SUBCUTANEOUS\* SOLUTION 4  
MG/0.5ML
- SUMAtriptan Succinate  
SUBCUTANEOUS\* 6 MG/0.5ML, 4  
MG/0.5ML

<b>QL Criteria</b>	2 boxes (4 doses) Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SUMAtriptan Succinate

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## Products Affected

- SUMAtriptan Succinate ORAL

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

# SUMAtriptan Succinate

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## Products Affected

- SUMAtriptan Succinate  
SUBCUTANEOUS\* SOLUTION 6  
MG/0.5ML

<b>QL Criteria</b>	8 vials Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SUMatriptan Succinate Refill

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## Products Affected

- SUMatriptan Succinate Refill  
SUBCUTANEOUS\*

<b>QL Criteria</b>	2 boxes (4 doses) Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Supartz

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## Products Affected

- Supartz INTRA-ARTICULAR\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sure Edge Glucose Monitor

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## Products Affected

- Sure Edge Glucose Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sure Edge Test

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## Products Affected

- Sure Edge Test

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



# SureChek Blood Glucose Monitor

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## Products Affected

- SureChek Blood Glucose Monitor  
DEVICE

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SureChek Blood Glucose Test

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## Products Affected

- SureChek Blood Glucose Test

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

# Sure-Test EasyPlus Mini Meter

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## Products Affected

- Sure-Test EasyPlus Mini Meter

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sure-Test EasyPlus Mini Test

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## Products Affected

- Sure-Test EasyPlus Mini Test

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

# Sutent

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## Products Affected

- Sutent

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sutent

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## Products Affected

- Sutent

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

# Syeda

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## Products Affected

- Syeda

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

# Sylatron

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## Products Affected

- Sylatron SUBCUTANEOUS\* KIT 200  
MCG, 4 X 200 MCG, 300 MCG, 600  
MCG, 4 X 300 MCG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Symbicort

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## Products Affected

- Symbicort

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

# Symbyax

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## Products Affected

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

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

# Symlin

## Products Affected

- Symlin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes, Type 2 Diabetes
<b>Exclusion Criteria</b>	Poor compliance with current insulin regimen, poor compliance with prescribed self-blood glucose monitoring, 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
<b>Required Medical Information</b>	A documented diagnosis of type I or type II diabetes and concurrent use of a rapid or short-acting insulin i.e., Humalog or regular insulin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 Months (initial)
<b>Other Criteria</b>	12 month extended approval if patient has demonstrated expected reduction in HbA1c since starting therapy.
<b>Notes/References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SymlinPen 120

## Products Affected

- SymlinPen 120 SUBCUTANEOUS\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes, Type 2 Diabetes
<b>Exclusion Criteria</b>	Poor compliance with current insulin regimen, poor compliance with prescribed self-blood glucose monitoring, 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
<b>Required Medical Information</b>	A documented diagnosis of type I or type II diabetes and concurrent use of a rapid or short-acting insulin i.e., Humalog or regular insulin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 Months (initial)
<b>Other Criteria</b>	12 month extended approval if patient has demonstrated expected reduction in HbA1c since starting therapy.
<b>Notes/References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SymLinPen 60

## Products Affected

- SymLinPen 60 SUBCUTANEOUS\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type 1 Diabetes, Type 2 Diabetes
<b>Exclusion Criteria</b>	Poor compliance with current insulin regimen, poor compliance with prescribed self-blood glucose monitoring, 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
<b>Required Medical Information</b>	A documented diagnosis of type I or type II diabetes and concurrent use of a rapid or short-acting insulin i.e., Humalog or regular insulin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 Months (initial)
<b>Other Criteria</b>	12 month extended approval if patient has demonstrated expected reduction in HbA1c since starting therapy.
<b>Notes/References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Synagis

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## Products Affected

- Synagis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Synagis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Synagis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Synjardy

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## Products Affected

- Synjardy

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

# Synribo

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## Products Affected

- Synribo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Synvisc

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## Products Affected

- Synvisc INTRA-ARTICULAR\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Synvisc One

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## Products Affected

- Synvisc One INTRA-ARTICULAR\*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Taclonex

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## Products Affected

- Taclonex EXTERNAL OINTMENT

<b>ST Criteria</b>	Documented trial and failure of 1 medium to high potency steroid indicated for patients condition.
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tacrolimus

## Products Affected

- Tacrolimus EXTERNAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Atopic dermatitis, Vitiligo
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. FOR PROTOPIC 0.03%: A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required) or a documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or child 2 years of age or older and either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

<b>Revision Date</b>	Prior Authorization: October 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Tafinlar

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## Products Affected

- Tafinlar

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tagrisso

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## Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Take Action

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## Products Affected

- Take Action

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



# Taltz

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## Products Affected

- Taltz

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Taltz.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Taltz.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Taltz.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Taltz.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tamiflu

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## Products Affected

- Tamiflu ORAL CAPSULE

<b>QL Criteria</b>	20 capsules Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tamiflu

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## Products Affected

- Tamiflu ORAL SUSPENSION  
RECONSTITUTED 6 MG/ML

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

# Tanzeum

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## Products Affected

- Tanzeum

<b>ST Criteria</b>	Trial and failure of 1 month each of Victoza and Trulicity
<b>QL Criteria</b>	4 pens Per 1 month
<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tarceva

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## Products Affected

- Tarceva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tasigna

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## Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
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: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Taytulla

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## Products Affected

- Taytulla

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

# Tazorac

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## Products Affected

- Tazorac

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Acne Vulgaris, plaque psoriasis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of Acne Vulgaris or plaque psoriasis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Taztia XT

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## Products Affected

- Taztia XT ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 120 MG, 180 MG,  
360 MG, 300 MG

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

# Taztia XT

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## Products Affected

- Taztia XT ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 240 MG

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

# Tecfidera

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## Products Affected

- Tecfidera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 CPDR Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tecfidera

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## Products Affected

- Tecfidera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Technivie

## Products Affected

- Technivie

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>QL Criteria</b>	2 EA Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tekamlo

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## Products Affected

- Tekamlo

<b>ST Criteria</b>	Documented step thru 2 preferred ACE-I or ARB. Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril), Univasc (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan), Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tekturna

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## Products Affected

- Tekturna

<b>ST Criteria</b>	Documented step thru 2 preferred ACE-I or ARB. Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril), Univasc (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan) , Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tekturna HCT

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## Products Affected

- Tekturna HCT

<b>ST Criteria</b>	Documented step thru 2 preferred ACE-I or ARB. Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril), Univas (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan), Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Telcare Blood Glucose Test

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## Products Affected

- Telcare Blood Glucose Test

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

# Telmisartan

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## Products Affected

- Telmisartan

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

# Telmisartan-Amlodipine

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## Products Affected

- Telmisartan-Amlodipine

<b>ST Criteria</b>	Documented step through AMLODIPINE in combination with TWO of the following: ATACAND, AVAPRO, COZAAR, MICARDIS
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Telmisartan-HCTZ

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## Products Affected

- Telmisartan-HCTZ

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

# Temazepam

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## Products Affected

- Temazepam ORAL CAPSULE 7.5 MG, 22.5 MG

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

# Temodar

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## Products Affected

- Temodar ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Temozolomide

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## Products Affected

- Temozolomide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Testim

## Products Affected

- Testim

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	10 grams Per 1 fill
<b>Notes/References</b>	Annual Review: 02/2016

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016



<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Testosterone

## Products Affected

- Testosterone TRANSDERMAL GEL 10 MG/ACT (2%), 50 MG/5GM (1%), 12.5 MG/ACT (1%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	10 grams Per 1 fill
<b>Notes/References</b>	

2016 Aetna Pharmacy Drug Guide- Value Small Group Formulary  
Updated 12/2016

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Testosterone

## Products Affected

- Testosterone TRANSDERMAL GEL 25 MG/2.5GM (1%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	10 grams Per 1 fill

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Testosterone Cypionate

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## Products Affected

- Testosterone Cypionate  
INTRAMUSCULAR\* SOLUTION 200  
MG/ML

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

# Testosterone Cypionate

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## Products Affected

- Testosterone Cypionate  
INTRAMUSCULAR\* SOLUTION 250  
MG/ML

<b>QL Criteria</b>	4 ml Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Testosterone Cypionate

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## Products Affected

- Testosterone Cypionate  
INTRAMUSCULAR\* SOLUTION 100  
MG/ML

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



# Tetrabenazine

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## Products Affected

- Tetrabenazine ORAL TABLET 12.5 MG

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

# Tetrabenazine

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## Products Affected

- Tetrabenazine ORAL TABLET 25 MG

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

# Teveten HCT

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## Products Affected

- Teveten HCT ORAL TABLET 600-25 MG

<b>ST Criteria</b>	Documented step through TWO of the following in combination with HCTZ: Candesartan, irbesartan, losartan and telmisartan
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tev-Tropin

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## Products Affected

- Tev-Tropin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TGT Blood Glucose Monitoring

## Products Affected

- TGT Blood Glucose Monitoring

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TGT Nicotine Step One

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## Products Affected

- TGT Nicotine Step One

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

# TGT Nicotine Step Three

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## Products Affected

- TGT Nicotine Step Three

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

# TGT Nicotine Step Two

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## Products Affected

- TGT Nicotine Step Two

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



# Thalomid

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## Products Affected

- Thalomid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Thrive

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## Products Affected

- Thrive MOUTH/THROAT GUM 2 MG

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

# TiaGABine HCl

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## Products Affected

- TiaGABine HCl ORAL TABLET 4 MG

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

# TiaGABine HCl

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## Products Affected

- TiaGABine HCl ORAL TABLET 2 MG

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

# Tiazac

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## Products Affected

- Tiazac ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 180 MG, 360 MG,  
420 MG, 120 MG, 300 MG

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

# Tiazac

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## Products Affected

- Tiazac ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 240 MG

<b>QL Criteria</b>	2 CP24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tilia Fe

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## Products Affected

- Tilia Fe

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

# Tirosint

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## Products Affected

- Tirosint

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



# Tivicay

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## Products Affected

- Tivicay

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

# Tivicay

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## Products Affected

- Tivicay

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

# Tivorbex

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## Products Affected

- Tivorbex

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

# Tobi

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## Products Affected

- Tobi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	56 ML Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tobi Podhaler

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## Products Affected

- Tobi Podhaler

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 CAPS Per 28 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tobramycin

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## Products Affected

- Tobramycin INHALATION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Aminoglycosides.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	10 ml Per 1 day
Notes/References	
Revision Date	Prior Authorization: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tolterodine Tartrate ER

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## Products Affected

- Tolterodine Tartrate ER

<b>QL Criteria</b>	999 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Topamax Sprinkle

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## Products Affected

- Topamax Sprinkle

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



# Topiramate

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## Products Affected

- Topiramate ORAL CAPSULE SPRINKLE

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

# Toprol XL

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## Products Affected

- Toprol XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 100 MG, 50 MG

<b>QL Criteria</b>	1.5 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Toprol XL

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## Products Affected

- Toprol XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 200 MG

<b>QL Criteria</b>	2 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Toprol XL

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## Products Affected

- Toprol XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 25 MG

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

# Toujeo SoloStar

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## Products Affected

- Toujeo SoloStar

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 or Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Type 1 or Type 2 Diabetes Mellitus
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy
<b>ST Criteria</b>	Documented one month trial of LEVEMIR
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Toviaz

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## Products Affected

- Toviaz

<b>ST Criteria</b>	Documented trial of 2 preferred alternatives: Vesicare OR Myrbetriq AND one generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tracleer

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## Products Affected

- Tracleer

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tradjenta

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## Products Affected

- Tradjenta

<b>ST Criteria</b>	A documented step through one month each of Januvia, Janumet, or Janumet XR, and either Onglyza or Kombiglyze XR
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# TraMADol HCl ER

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## Products Affected

- TraMADol HCl ER ORAL TABLET  
EXTENDED RELEASE 24 HR\*

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

# TraMADol HCl ER (Biphasic)

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## Products Affected

- TraMADol HCl ER (Biphasic)

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

# Tramadol-Acetaminophen

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## Products Affected

- Tramadol-Acetaminophen

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

# Tranexamic Acid

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## Products Affected

- Tranexamic Acid ORAL

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

# Travoprost

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## Products Affected

- Travoprost

<b>ST Criteria</b>	A documented step through one week of latanoprost and one week of Travatan Z
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretinoin

## Products Affected

- Tretinoin EXTERNAL CREAM
- Tretinoin EXTERNAL GEL 0.025 %

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	50 grams Per 1 fill
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Tretinoin

## Products Affected

- Tretinoin EXTERNAL GEL 0.01 %

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tretinoin Microsphere

## Products Affected

- Tretinoin Microsphere

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretinoin Microsphere Pump

## Products Affected

- Tretinoin Microsphere Pump

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretin-X

## Products Affected

- Tretin-X EXTERNAL KIT 0.05 %  
CREAM, 0.1 % CREAM, 0.025 %  
CREAM

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Tretin-X

## Products Affected

- Tretin-X EXTERNAL CREAM 0.075 %

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of 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, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	Prior authorization only applies for members greater than 35 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretin-X

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## Products Affected

- Tretin-X EXTERNAL CREAM 0.0375 %

<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretten

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## Products Affected

- Tretten

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tribenzor

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## Products Affected

- Tribenzor

<b>ST Criteria</b>	Documented step through AMLODIPINE in combination with TWO of the following: ATACAND HCT, AVALIDE, HYZAAR, MICARDIS HCT
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tricor

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## Products Affected

- Tricor

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

# Tri-Legest Fe

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## Products Affected

- Tri-Legest Fe

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

# Tri-Linyah

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## Products Affected

- Tri-Linyah

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

# Trilipix

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## Products Affected

- Trilipix

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

# TriNessa (28)

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## Products Affected

- TriNessa (28)

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

# Tri-Norinyl (28)

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## Products Affected

- Tri-Norinyl (28)

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

# Trintellix

## Products Affected

- Trintellix

PA Criteria	Criteria Details
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of Major Depressive Disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's 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.)
<b>ST Criteria</b>	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tri-Previfem

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## Products Affected

- Tri-Previfem

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



# Tri-Sprintec

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## Products Affected

- Tri-Sprintec

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

# Triumeq

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## Products Affected

- Triumeq

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

# Trivora (28)

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## Products Affected

- Trivora (28)

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

# Trokendi XR

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## Products Affected

- Trokendi XR

<b>ST Criteria</b>	Documented step through TOPAMAX
<b>QL Criteria</b>	1 CP24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Trospium Chloride

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## Products Affected

- Trospium Chloride

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

# Trospium Chloride ER

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## Products Affected

- Trospium Chloride ER

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

# TRUE2go Blood Glucose Monitor

## Products Affected

- TRUE2go Blood Glucose Monitor

PA Criteria	Criteria Details
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TRUEresult Blood Glucose

## Products Affected

- TRUEresult Blood Glucose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# TRUEtest Test

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## Products Affected

- TRUEtest Test

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

# TrueTrack Blood Glucose

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## Products Affected

- TrueTrack Blood Glucose KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TrueTrack Smart System

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## Products Affected

- TrueTrack Smart System

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a physical limitation that makes utilization of a 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 Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years, 1 meter per year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 KIT Per 365 DAYs
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TrueTrack Test

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## Products Affected

- TrueTrack Test

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

# Trulicity

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## Products Affected

- Trulicity

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

# Tudorza Pressair

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## Products Affected

- Tudorza Pressair INHALATION  
AEROSOL POWDER, BREATH  
ACTIVATED 400 MCG/ACT

<b>ST Criteria</b>	Trial of 1 month each of Spiriva and Incruse Ellipta
<b>QL Criteria</b>	1 inhaler Per 30 fills
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TussiCaps

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## Products Affected

- TussiCaps

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

# Twynsta

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## Products Affected

- Twynsta

<b>ST Criteria</b>	Documented step through AMLODIPINE in combination with TWO of the following: ATACAND, AVAPRO, COZAAR, MICARDIS
<b>QL Criteria</b>	1 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tybost

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## Products Affected

- Tybost

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

# Tykerb

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## Products Affected

- Tykerb

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tysabri

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## Products Affected

- Tysabri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tyvaso

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## Products Affected

- Tyvaso

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 SOLN Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tyvaso Refill

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## Products Affected

- Tyvaso Refill

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tyvaso Starter

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## Products Affected

- Tyvaso Starter

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tyzeka

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## Products Affected

- Tyzeka

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

# Uceris

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## Products Affected

- Uceris

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Active mild to moderate ulcerative colitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of ACTIVE mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge, requiring induction of remission.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 canisters Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Uceris

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## Products Affected

- Uceris ORAL

<b>ST Criteria</b>	A documented trial of Asacol HD, Delzicol, Lialda or Pentasa
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ulesfia

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## Products Affected

- Ulesfia

<b>QL Criteria</b>	3 bottles Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uloric

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## Products Affected

- Uloric

<b>ST Criteria</b>	Documented step through ALLOPURINOL
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ultima Test

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## Products Affected

- Ultima Test

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

# Ultracet

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## Products Affected

- Ultracet

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

# Ultram ER

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## Products Affected

- Ultram ER ORAL TABLET EXTENDED  
RELEASE 24 HR\* 100 MG, 300 MG

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

# Ultram ER

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## Products Affected

- Ultram ER ORAL TABLET EXTENDED  
RELEASE 24 HR\* 200 MG

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

# UltraTRAK Active

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## Products Affected

- UltraTRAK Active

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# UltraTRAK PRO

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## Products Affected

- UltraTRAK PRO

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# UltraTRAK PRO Test

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## Products Affected

- UltraTRAK PRO Test

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

# UltraTRAK Ultimate Monitor

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## Products Affected

- UltraTRAK Ultimate Monitor

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# UltraTRAK Ultimate Test

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## Products Affected

- UltraTRAK Ultimate Test

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

# Ultresa

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## Products Affected

- Ultresa

<b>ST Criteria</b>	Documented step through CREON AND ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uptravi

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## Products Affected

- Uptravi ORAL TABLET 1600 MCG, 1200 MCG, 400 MCG, 600 MCG, 1000 MCG, 1400 MCG, 800 MCG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uptravi

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## Products Affected

- Uptravi ORAL TABLET 200 MCG
- Uptravi ORAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Utibron Neohaler

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## Products Affected

- Utibron Neohaler

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



# Valchlor

## Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 GM Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valcyte

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## Products Affected

- Valcyte ORAL TABLET

<b>QL Criteria</b>	102 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ValGANciclovir HCl

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## Products Affected

- ValGANciclovir HCl ORAL SOLUTION  
RECONSTITUTED

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopi.html">http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopi.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ValGANciclovir HCl

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## Products Affected

- ValGANciclovir HCl ORAL TABLET

<b>QL Criteria</b>	102 TABS Per 30 DAYs
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valsartan

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## Products Affected

- Valsartan

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

# Valsartan-Hydrochlorothiazide

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## Products Affected

- Valsartan-Hydrochlorothiazide

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

# Varubi

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## Products Affected

- Varubi

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

# Vascepa

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## Products Affected

- Vascepa ORAL CAPSULE 1 GM

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



# Vecamyl

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## Products Affected

- Vecamyl

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of trial and failure with four antihypertensive drugs from at least three different therapeutic subclasses, and documentation of moderately severe to severe hypertension (blood pressure greater than or equal to 160/100 mmHg) or documentation of malignant hypertension without complications (blood pressure greater or equal to 180/120 mmHg) with retinal hemorrhages, exudates, or papilledema
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year

PA Criteria	Criteria Details
Other Criteria	<p>Examples of antihypertensive drugs listed by therapeutic subclasses:DIURETICS: HydroDiuril, Microzide (hydrochlorothiazide), Hygroton (chlorthalidone), Diuril (chlorthiazide), Lasix (furosemide), Midamor (amiloride), Dyazide, Maxzide (triamterene-hydrochlorothiazide). BETA BLOCKERS: Tenormin (atenolol), Toprol XL (metoprolol succinate), Lopressor (metoprolol tartrate), Zebeta (bisoprolol), Coreg (carvedilol), Inderal LA (propranolol). CALCIUM CHANNEL BLOCKERS: Adalat CC, Procardia XL (nifedipine), Calan, Isoptin, Verelan (verapamil), Cardizem, Cartia (diltiazem), Norvasc (amlodipine), Sular (nisoldipine), Plendil (felodipine). ANGIOTENSIN CONVERTING ENZYME INHIBITORS (ACEI) &amp; ACEI COMBINATIONS: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril),Univasc (moexipril). ANGIOTENSION RECEPTOR BLOCKER (ARB) &amp; ARB COMBINATIONS: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan) , Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)</p>
QL Criteria	10 tabs Per 1 Day
Notes/ References	
Revision Date	<p>Prior Authorization: October 05, 2015  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Veletri

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## Products Affected

- Veletri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Velivet

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## Products Affected

- Velivet

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Veltassa.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Veltassa.html</a>
Exclusion 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: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Veltin

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## Products Affected

- Veltin

<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venclexta

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## Products Affected

- Venclexta ORAL TABLET 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	8 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venclexta

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## Products Affected

- Venclexta ORAL TABLET 100 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Venclexta

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## Products Affected

- Venclexta ORAL TABLET 10 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	40 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venclexta Starting Pack

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## Products Affected

- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOP L/Venclexta.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 pack Per 28 days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl

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## Products Affected

- Venlafaxine HCl ORAL TABLET 50 MG

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

# Venlafaxine HCl

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## Products Affected

- Venlafaxine HCl ORAL TABLET 25 MG,  
100 MG

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

# Venlafaxine HCl

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## Products Affected

- Venlafaxine HCl ORAL TABLET 37.5 MG

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

# Venlafaxine HCl

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## Products Affected

- Venlafaxine HCl ORAL TABLET 75 MG

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

# Venlafaxine HCl ER

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## Products Affected

- Venlafaxine HCl ER ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 75  
MG, 37.5 MG

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

# Venlafaxine HCl ER

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## Products Affected

- Venlafaxine HCl ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 225 MG,  
37.5 MG, 75 MG

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



# Venlafaxine HCl ER

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## Products Affected

- Venlafaxine HCl ER ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 150  
MG

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

# Venlafaxine HCl ER

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## Products Affected

- Venlafaxine HCl ER ORAL TABLET  
EXTENDED RELEASE 24 HR\* 150 MG

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

# Ventavis

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## Products Affected

- Ventavis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Veramyst

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## Products Affected

- Veramyst

<b>ST Criteria</b>	Trial of 2 weeks each of Nasonex and one of the following: Flonase, Nasalide, or Nasacort 24HR OTC
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Verapamil HCl ER

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## Products Affected

- Verapamil HCl ER ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 300  
MG, 100 MG

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

# Verapamil HCl ER

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## Products Affected

- Verapamil HCl ER ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 200  
MG

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

# Versacloz

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## Products Affected

- Versacloz

<b>ST Criteria</b>	Documented step through Clozaril tablets
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# VESIcare

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## Products Affected

- VESIcare

<b>ST Criteria</b>	Documented trial of 1 preferred generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vestura

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## Products Affected

- Vestura

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

# Viberzi

## Products Affected

- Viberzi

PA Criteria	Criteria Details
<b>Covered Uses</b>	Diarrhea-predominant irritable bowel syndrome (IBS)
<b>Exclusion Criteria</b>	No known or suspected history of any of the following: diagnosis of pancreatitis, diagnosis of alcoholism, member drinks more than 3 alcoholic beverages/day, severe (Child-Pugh C) hepatic impairment, or anatomic or biochemical abnormalities of the gastrointestinal tract (e.g., biliary duct obstruction, sphincter of Oddi dysfunction, or severe constipation)
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	A documented diagnosis of diarrhea-predominant irritable bowel syndrome (IBS)
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Victory AGM-4000 Test

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## Products Affected

- Victory AGM-4000 Test

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

# Victory Blood Glucose System

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## Products Affected

- Victory Blood Glucose System

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Victoza

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## Products Affected

- Victoza SUBCUTANEOUS\*

<b>QL Criteria</b>	1 box-2 or 3 pens Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Victrelis

## Products Affected

- Victrelis

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	10 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viekira Pak

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## Products Affected

- Viekira Pak

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viekira XR

## Products Affected

- Viekira XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Viibryd

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## Products Affected

- Viibryd ORAL KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>Notes/References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viibryd

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## Products Affected

- Viibryd ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viibryd

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## Products Affected

- Viibryd ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Major depressive disorder
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	Annual Review: 05/2016
<b>Revision Date</b>	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vimizim

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## Products Affected

- Vimizim

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vimpat

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## Products Affected

- Vimpat ORAL SOLUTION

<b>QL Criteria</b>	40 ML Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vimpat

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## Products Affected

- Vimpat ORAL TABLET

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

# Viokace

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## Products Affected

- Viokace

<b>ST Criteria</b>	Documented step through CREON AND ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viorele

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## Products Affected

- Viorele

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



# Viramune XR

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## Products Affected

- Viramune XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 100 MG

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

# Viramune XR

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## Products Affected

- Viramune XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 400 MG

<b>QL Criteria</b>	1 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viread

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## Products Affected

- Viread ORAL TABLET

<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vistogard

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## Products Affected

- Vistogard

<b>QL Criteria</b>	20 packs Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vivelle

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## Products Affected

- Vivelle

<b>QL Criteria</b>	8 patches Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vivelle-Dot

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## Products Affected

- Vivelle-Dot

<b>QL Criteria</b>	8 patches Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vivlodex

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## Products Affected

- Vivlodex

<b>ST Criteria</b>	Trial of one month each of two generic non steroidal anti-inflammatory drugs
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vocal Point Blood Glucose Test

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## Products Affected

- Vocal Point Blood Glucose Test

<b>QL Criteria</b>	300 strips Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vogelxo

## Products Affected

- Vogelxo TRANSDERMAL GEL 50 MG/5GM (1%)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	10 grams Per 1 Day

<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vogelxo Pump

## Products Affected

- Vogelxo Pump

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
<b>Exclusion Criteria</b>	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
<b>Required Medical Information</b>	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 laboratory's 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 laboratory's 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one month of Androgel 1.62%
<b>QL Criteria</b>	10 grams Per 1 Day
<b>Notes/References</b>	Annual Review: 02/2016

<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Voltaren

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## Products Affected

- Voltaren TRANSDERMAL

<b>QL Criteria</b>	200 GM Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 15, 2016

# Vonvendi

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## Products Affected

- Vonvendi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Votrient

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## Products Affected

- Votrient

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vpriv

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## Products Affected

- Vpriv

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vraylar

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## Products Affected

- Vraylar ORAL CAPSULE 1.5 MG

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	4 capsule Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vraylar

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## Products Affected

- Vraylar ORAL CAPSULE 6 MG, 4.5 MG

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vraylar

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## Products Affected

- Vraylar ORAL

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vraylar

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## Products Affected

- Vraylar ORAL CAPSULE 3 MG

<b>ST Criteria</b>	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) PLUS Latuda
<b>QL Criteria</b>	2 capsule Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vytorin

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## Products Affected

- Vytorin ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG

<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vytorin

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## Products Affected

- Vytorin ORAL TABLET 10-80 MG

<b>ST Criteria</b>	A documented step through one generic statin medication (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) and Zetia
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vyvanse

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## Products Affected

- Vyvanse

<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# WaveSense KeyNote Pro Meter

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## Products Affected

- WaveSense KeyNote Pro Meter

<b>QL Criteria</b>	1 meter Per 1 year
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# WaveSense Presto

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## Products Affected

- WaveSense Presto

<b>QL Criteria</b>	300 strips Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wellbutrin

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## Products Affected

- Wellbutrin

<b>QL Criteria</b>	6 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wellbutrin SR

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## Products Affected

- Wellbutrin SR

<b>QL Criteria</b>	2 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wera

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## Products Affected

- Wera

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 60

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## Products Affected

- Wide-Seal Diaphragm 60

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 65

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## Products Affected

- Wide-Seal Diaphragm 65

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 70

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## Products Affected

- Wide-Seal Diaphragm 70

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 75

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## Products Affected

- Wide-Seal Diaphragm 75

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Wide-Seal Diaphragm 80

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## Products Affected

- Wide-Seal Diaphragm 80

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 85

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## Products Affected

- Wide-Seal Diaphragm 85

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 90

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## Products Affected

- Wide-Seal Diaphragm 90

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 95

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## Products Affected

- Wide-Seal Diaphragm 95

<b>QL Criteria</b>	1 diaphragm Per 1 year
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wilate

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## Products Affected

- Wilate INTRAVENOUS\* KIT
- Wilate INTRAVENOUS\* SOLUTION RECONSTITUTED 500-500 UNIT, 1000-1000 UNIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wymzya Fe

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## Products Affected

- Wymzya Fe

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xalatan

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## Products Affected

- Xalatan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	open-angle glaucoma, ocular hypertension
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of glaucoma or ocular hypertension
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one week of latanoprost and one week of Travatan Z
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xalkori

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## Products Affected

- Xalkori

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 capsules Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Xanax XR

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## Products Affected

- Xanax XR

<b>QL Criteria</b>	2 TB24 Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xartemis XR

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## Products Affected

- Xartemis XR

<b>ST Criteria</b>	Documented step through TWO of the following: MORPHINE, OXYCODONE, HYDROMORPHONE
<b>QL Criteria</b>	4 tablets Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xeljanz

## Products Affected

- Xeljanz

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html</a>
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xeljanz XR

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## Products Affected

- Xeljanz XR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html</a>
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xeloda

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## Products Affected

- Xeloda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xenazine

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## Products Affected

- Xenazine ORAL TABLET 12.5 MG

<b>QL Criteria</b>	8 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xenazine

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## Products Affected

- Xenazine ORAL TABLET 25 MG

<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xeomin

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## Products Affected

- Xeomin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Xgeva

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## Products Affected

- Xgeva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_diasease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_diasease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xifaxan

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## Products Affected

- Xifaxan ORAL TABLET 550 MG

<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/ References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xifaxan

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## Products Affected

- Xifaxan ORAL TABLET 200 MG

<b>QL Criteria</b>	9 tablets Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xigduo XR

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## Products Affected

- Xigduo XR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 5-1000 MG

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xigduo XR

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## Products Affected

- Xigduo XR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 10-1000 MG, 10-500  
MG, 5-500 MG

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xolair

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## Products Affected

- Xolair

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xopenex HFA

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## Products Affected

- Xopenex HFA

<b>ST Criteria</b>	Documented step through one week each of VENTOLIN HFA AND PROAIR
<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: November 09, 2016 Quantity Limits: August 25, 2015

# Xtampza ER

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## Products Affected

- Xtampza ER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	A documented step through one month each of two preferred alternatives which include Butrans, Hysingla ER, and Oxycontin
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: April 11, 2016 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
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: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xulane

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## Products Affected

- Xulane

<b>QL Criteria</b>	1 box (3 patches) Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xuriden

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## Products Affected

- Xuriden

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 packets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xyntha

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## Products Affected

- Xyntha INTRAVENOUS\* KIT 2000 UNIT, 500 UNIT, 250 UNIT, 1000 UNIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xyntha Solofuse

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## Products Affected

- Xyntha Solofuse

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xyrem

## Products Affected

- Xyrem

PA Criteria	Criteria Details
<b>Covered Uses</b>	Excessive daytime sleepiness associated with narcolepsy, Cataplexy associated with narcolepsy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS IN ASSOCIATION WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of narcolepsy, such as MSLT, clinical progress notes, and documentation of failure of an adequate trial of at least two of the immediate release stimulants (Dexedrine, Ritalin, Adderall), and documentation of failure of an adequate trial of Nuvigil. FOR THE TREATMENT OF CATAPLEXY IN ASSOCIATION WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of narcolepsy, such as MSLT, clinical progress notes, and documentation of failure of an adequate trial of at least two of the immediate release stimulants (Dexedrine, Ritalin, Adderall), and documentation of failure of an adequate trial of an antidepressant.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Sleep specialist, pulmonologist, neurologist, or psychiatrist
<b>Coverage Duration</b>	3 months, extended approval based on therapeutic response
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: October 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xyzal

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## Products Affected

- Xyzal ORAL TABLET

<b>QL Criteria</b>	1 TABS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Yasmin 28

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## Products Affected

- Yasmin 28

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# YAZ

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## Products Affected

- YAZ

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Yervoy

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## Products Affected

- Yervoy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/yervoy.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/yervoy.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zaleplon

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## Products Affected

- Zaleplon

<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zarah

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## Products Affected

- Zarah

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 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: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html</a>
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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zecuity

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## Products Affected

- Zecuity

<b>QL Criteria</b>	4 patches Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zegerid

## Products Affected

- Zegerid ORAL PACKET 40-1680 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). 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	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zegerid OTC

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## Products Affected

- Zegerid OTC

<b>QL Criteria</b>	1 capsule Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zelapar

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## Products Affected

- Zelapar

<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zelboraf

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## Products Affected

- Zelboraf

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	8 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zembrace SymTouch

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## Products Affected

- Zembrace SymTouch

<b>ST Criteria</b>	Documented trial and failure of generic Imitrex injection
<b>QL Criteria</b>	8 syringes Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zemplar

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## Products Affected

- Zemplar ORAL CAPSULE 2 MCG, 1 MCG

<b>QL Criteria</b>	1 CAPS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenatane

## Products Affected

- Zenatane ORAL CAPSULE 40 MG, 10 MG, 20 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: Patient requires more than 2 capsules per day to reach the appropriate dose for weight, and this is the members FIRST course of therapy or member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month holiday), and member has recieved a cumulative dose of less than 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>ST Criteria</b>	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
<b>QL Criteria</b>	2 capsules Per 1 DAYS
<b>Notes/References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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# Zenatane

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## Products Affected

- Zenatane ORAL CAPSULE 30 MG

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	Annual Review: 02/2016
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenchant

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## Products Affected

- Zenchant

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenchent FE

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## Products Affected

- Zenchent FE

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zepatier

## Products Affected

- Zepatier

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html">http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html</a>
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zetia

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## Products Affected

- Zetia

<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zetonna

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## Products Affected

- Zetonna

<b>ST Criteria</b>	Trial of 2 weeks each of Nasonex and one of the following: Flonase, Nasalide, or Nasacort 24HR OTC
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ziana

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## Products Affected

- Ziana

<b>ST Criteria</b>	Documented step through Retin-A
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zinbryta

## Products Affected

- Zinbryta

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html">http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html</a>
QL Criteria	1 injection Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zioptan

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## Products Affected

- Zioptan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	open-angle glaucoma, ocular hypertension
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of glaucoma or ocular hypertension
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>ST Criteria</b>	A documented step through one week of latanoprost and one week of Travatan Z
<b>Notes/References</b>	Annual Review: 03/2016
<b>Revision Date</b>	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ziprasidone HCl

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## Products Affected

- Ziprasidone HCl

<b>QL Criteria</b>	2 capsules Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zocor

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## Products Affected

- Zocor

<b>QL Criteria</b>	1 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zohydro ER

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## Products Affected

- Zohydro ER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step Therapy
<b>ST Criteria</b>	A documented step through one month each of two preferred alternatives which include Butrans, Hysingla ER, and Oxycontin
<b>Notes/References</b>	Annual Review: 06/2016
<b>Revision Date</b>	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoledronic Acid

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## Products Affected

- Zoledronic Acid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolanza

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## Products Affected

- Zolanza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 capsules Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZOLMitriptan

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## Products Affected

- ZOLMitriptan ORAL TABLET 2.5 MG

<b>QL Criteria</b>	3 tablets Per 30 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZOLMitriptan

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## Products Affected

- ZOLMitriptan ORAL TABLET 5 MG
- ZOLMitriptan ORAL TABLET DISPERSIBLE 5 MG

<b>QL Criteria</b>	30 tablet Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZOLMitriptan

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## Products Affected

- ZOLMitriptan ORAL TABLET  
DISPERSIBLE 2.5 MG

<b>QL Criteria</b>	6 tablets Per 30 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoloft

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## Products Affected

- Zoloft ORAL TABLET 50 MG

<b>QL Criteria</b>	1.5 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoloft

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## Products Affected

- Zoloft ORAL CONCENTRATE

<b>QL Criteria</b>	10 ml Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zoloft

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## Products Affected

- Zoloft ORAL TABLET 100 MG

<b>QL Criteria</b>	2 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoloft

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## Products Affected

- Zoloft ORAL TABLET 25 MG

<b>QL Criteria</b>	1 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolpidem Tartrate

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## Products Affected

- Zolpidem Tartrate ORAL

<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolpidem Tartrate ER

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## Products Affected

- Zolpidem Tartrate ER

<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomacton

## Products Affected

- Zomacton

PA Criteria	Criteria Details
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>ST Criteria</b>	<a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zometa

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## Products Affected

- Zometa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html">http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

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## Products Affected

- Zomig ORAL

<b>QL Criteria</b>	3 tablets Per 30 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

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## Products Affected

- Zomig NASAL SOLUTION 5 MG

<b>ST Criteria</b>	Documented step through one month of THREE of the following: NARATRIPTAN, RIZATRIPTAN, SUMATRIPTAN, ZOLMITRIPTAN
<b>QL Criteria</b>	1 box (6 doses) Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zomig ZMT

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## Products Affected

- Zomig ZMT

<b>QL Criteria</b>	3 tablets Per 30 dayss
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zorbtive

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## Products Affected

- Zorbtive

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zorvolex

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## Products Affected

- Zorvolex

<b>ST Criteria</b>	Documented trial and failure of one generic non steroidal anti-inflammatory drug (NSAID)
<b>QL Criteria</b>	3 CAPS Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Zovia 1/35E (28)

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### Products Affected

- Zovia 1/35E (28)

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Zovia 1/50E (28)

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### Products Affected

- Zovia 1/50E (28)

<b>QL Criteria</b>	1.5 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zubsolv

## Products Affected

- Zubsolv SUBLINGUAL TABLET  
SUBLINGUAL 11.4-2.9 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

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PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>ST Criteria</b>	A documented step through one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zubsolv

## Products Affected

- Zubsolv SUBLINGUAL TABLET  
SUBLINGUAL 8.6-2.1 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

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Updated 12/2016



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>ST Criteria</b>	A documented step through one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zubsolv

## Products Affected

- Zubsolv SUBLINGUAL TABLET  
SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

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PA Criteria	Criteria Details
Other Criteria	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
ST Criteria	A documented step through one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 Tabs Per 1 DAYS
Notes/References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zubsolv

## Products Affected

- Zubsolv SUBLINGUAL TABLET  
SUBLINGUAL 2.9-0.71 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months = current enrollement

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Updated 12/2016

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp</a> . Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>ST Criteria</b>	A documented step through one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/References</b>	Annual Review: 04/2016
<b>Revision Date</b>	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zurampic

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## Products Affected

- Zurampic

<b>ST Criteria</b>	A documented step through allopurinol or febuxostat
<b>QL Criteria</b>	1 tablet Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyban

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## Products Affected

- Zyban

<b>QL Criteria</b>	2 tablet Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zydelig

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## Products Affected

- Zydelig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 CAP Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zykadia

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## Products Affected

- Zykadia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	5 CAP Per 1 DAYS
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA

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## Products Affected

- ZyPREXA ORAL TABLET 15 MG, 20 MG, 7.5 MG, 10 MG, 5 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	1 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA

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## Products Affected

- ZyPREXA ORAL TABLET 2.5 MG

<b>ST Criteria</b>	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
<b>QL Criteria</b>	2 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA Zydys

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## Products Affected

- ZyPREXA Zydys

<b>ST Criteria</b>	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
<b>QL Criteria</b>	1 tabs Per 1 DAYS
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zytiga

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## Products Affected

- Zytiga

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Refer to the clinical policy bulletin for details: <a href="http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html">http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html</a>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Refer to the clinical policy bulletin above for details.
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 tablets Per 1 day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyvox

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## Products Affected

- Zyvox ORAL SUSPENSION  
RECONSTITUTED

<b>QL Criteria</b>	1 bottle Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyvox

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## Products Affected

- Zyvox ORAL TABLET

<b>QL Criteria</b>	28 tablets Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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TGT Nicotine Step Two	1552	Tretin-X EXTERNAL CREAM 0.075 %	1589
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Veletri.....	1651	Viibryd ORAL TABLET.....	1682
Velivet.....	1652	Viibryd ORAL TABLET.....	1683
Veltassa.....	1653	Vimizim.....	1684
Veltin.....	1654	Vimpat ORAL SOLUTION.....	1685
Venclexta ORAL TABLET 10 MG.....	1657	Vimpat ORAL TABLET.....	1686
Venclexta ORAL TABLET 100 MG.....	1656	Viokace.....	1687
Venclexta ORAL TABLET 50 MG.....	1655	Viorele.....	1688
Venclexta Starting Pack.....	1658	Viramune XR ORAL TABLET EXTENDED	
Venlafaxine HCl ER ORAL CAPSULE		RELEASE 24 HR* 100 MG.....	1689
EXTENDED RELEASE 24 HOUR 150 MG		Viramune XR ORAL TABLET EXTENDED	
.....	1665	RELEASE 24 HR* 400 MG.....	1690
Venlafaxine HCl ER ORAL CAPSULE		Viread ORAL TABLET.....	1691
EXTENDED RELEASE 24 HOUR 75 MG,		Vistogard.....	1692
37.5 MG.....	1663	Vivelle.....	1693

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Vivelle-Dot.....	1694	Xgeva.....	1737
Vivlodex.....	1695	Xifaxan ORAL TABLET 200 MG.....	1739
Vocal Point Blood Glucose Test.....	1696	Xifaxan ORAL TABLET 550 MG.....	1738
Vogelxo Pump.....	1699	Xigduo XR ORAL TABLET EXTENDED	
Vogelxo TRANSDERMAL GEL 50 MG/5GM		RELEASE 24 HR* 10-1000 MG, 10-500 MG,	
(1%).....	1697	5-500 MG.....	1741
Voltaren TRANSDERMAL.....	1701	Xigduo XR ORAL TABLET EXTENDED	
Vonvendi.....	1702	RELEASE 24 HR* 5-1000 MG.....	1740
Votrient.....	1703	Xolair.....	1742
Vpriv.....	1704	Xopenex HFA.....	1743
Vraylar ORAL.....	1707	Xtampza ER.....	1744
Vraylar ORAL CAPSULE 1.5 MG.....	1705	Xtandi.....	1745
Vraylar ORAL CAPSULE 3 MG.....	1708	Xulane.....	1746
Vraylar ORAL CAPSULE 6 MG, 4.5 MG		Xuriden.....	1747
.....	1706	Xyntha INTRAVENOUS* KIT 2000 UNIT,	
Vytorin ORAL TABLET 10-10 MG, 10-20		500 UNIT, 250 UNIT, 1000 UNIT.....	1748
MG, 10-40 MG.....	1709	Xyntha Solofuse.....	1749
Vytorin ORAL TABLET 10-80 MG.....	1710	Xyrem.....	1750
Vyvanse.....	1711	Xyzal ORAL TABLET.....	1751
WaveSense KeyNote Pro Meter.....	1712	Yasmin 28.....	1752
WaveSense Presto.....	1713	YAZ.....	1753
Wellbutrin.....	1714	Yervoy.....	1754
Wellbutrin SR.....	1715	Zaleplon.....	1755
Wera.....	1716	Zarah.....	1756
Wide-Seal Diaphragm 60.....	1717	Zavesca.....	1757
Wide-Seal Diaphragm 65.....	1718	Zecuity.....	1758
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Wide-Seal Diaphragm 75.....	1720	Zegerid OTC.....	1760
Wide-Seal Diaphragm 80.....	1721	Zelapar.....	1761
Wide-Seal Diaphragm 85.....	1722	Zelboraf.....	1762
Wide-Seal Diaphragm 90.....	1723	Zembrace SymTouch.....	1763
Wide-Seal Diaphragm 95.....	1724	Zemplar ORAL CAPSULE 2 MCG, 1 MCG	
Wilate INTRAVENOUS* KIT.....	1725	.....	1764
Wilate INTRAVENOUS* SOLUTION		Zenatane ORAL CAPSULE 30 MG.....	1766
RECONSTITUTED 500-500 UNIT,		Zenatane ORAL CAPSULE 40 MG, 10 MG,	
1000-1000 UNIT.....	1725	20 MG.....	1765
Wymzya Fe.....	1726	Zenchent.....	1767
Xalatan.....	1727	Zenchent FE.....	1768
Xalkori.....	1728	Zepatier.....	1769
Xanax XR.....	1729	Zetia.....	1770
Xartemis XR.....	1730	Zetonna.....	1771
Xeljanz.....	1731	Ziana.....	1772
Xeljanz XR.....	1732	Zinbryta.....	1773
Xeloda.....	1733	Zioptan.....	1774
Xenazine ORAL TABLET 12.5 MG.....	1734	Ziprasidone HCl.....	1775
Xenazine ORAL TABLET 25 MG.....	1735	Zocor.....	1776
Xeomin.....	1736	Zohydro ER.....	1777

Zoledronic Acid .....	1778
Zolinza .....	1779
ZOLMitriptan ORAL TABLET 2.5 MG ..	1780
ZOLMitriptan ORAL TABLET 5 MG .....	1781
ZOLMitriptan ORAL TABLET DISPERSIBLE 2.5 MG .....	1782
ZOLMitriptan ORAL TABLET DISPERSIBLE 5 MG .....	1781
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Zoloft ORAL TABLET 100 MG .....	1785
Zoloft ORAL TABLET 25 MG .....	1786
Zoloft ORAL TABLET 50 MG .....	1783
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Zolpidem Tartrate ORAL .....	1787
Zomacton .....	1789
Zometa .....	1790
Zomig NASAL SOLUTION 5 MG .....	1792
Zomig ORAL .....	1791
Zomig ZMT .....	1793
Zorbtive .....	1794
Zorvolex .....	1795
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Zubsolv SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG .....	1798
Zubsolv SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG .....	1804
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Zydelig .....	1808
Zykadia .....	1809
ZyPREXA ORAL TABLET 15 MG, 20 MG, 7.5 MG, 10 MG, 5 MG .....	1810
ZyPREXA ORAL TABLET 2.5 MG .....	1811
ZyPREXA Zydis .....	1812
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