

2016 Aetna Pharmacy Drug Guide Value Plus Formulary

Abilify

Products Affected

- ABILIFY ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	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)
QL Criteria	1 tab Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Abilify

Products Affected

- ABILIFY ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	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)
QL Criteria	30 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Abilify Discmelt

Products Affected

- ABILIFY DISCMELT

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	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)
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

Absorica

Products Affected

- ABSORICA

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	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.
ST Criteria	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Absorica

Products Affected

- ABSORICA

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	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.
ST Criteria	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Abstral

Products Affected

- ABSTRAL

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))
ST Criteria	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
QL Criteria	4 tablet Per 1 Day

Notes/ References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Abstral

Products Affected

- ABSTRAL

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))
ST Criteria	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
QL Criteria	4 tablets Per 1 Day

Notes/ References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acamprosate Calcium

Products Affected

- *acamprosate calcium*

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

Accu-Chek Aviva

Products Affected

- ACCU-CHEK AVIVA IN VITRO STRIP

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 Days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek SmartView

Products Affected

- ACCU-CHEK SMARTVIEW

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 Days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 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 tab 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

Acitretin

Products Affected

- *acitretin oral capsule 25 mg, 10 mg*

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

Actemra

Products Affected

- ACTEMRA INTRAVENOUS*

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

Actemra

Products Affected

- ACTEMRA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Actemra.html
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

Acticlate

Products Affected

- ACTICLATE

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

Acticlate

Products Affected

- ACTICLATE

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

Actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/actimmune.htm 1
Exclusion Criteria	
Required Medical 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

Actiq

Products Affected

- ACTIQ

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A. Documentation of already receiving and who are tolerant to opioid therapy, and documentation on intolerance of two (2) other immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	FOR SUBSYS: Documentation of intolerance to Actiq. FOR ABSTRAL, FENTORA, LAZANDA, and ONSOLIS: Documentation of intolerance to Actiq AND Subsys.
ST Criteria	Documented trial or intolerance to two (2) immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone
QL Criteria	4 lozenges Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Activella

Products Affected

- ACTIVELLA

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

Actonel

Products Affected

- ACTONEL ORAL TABLET 5 MG, 30 MG

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

Actonel

Products Affected

- ACTONEL ORAL TABLET 35 MG

ST Criteria	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
QL Criteria	4 tablets Per 28 months
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actonel

Products Affected

- ACTONEL ORAL TABLET 150 MG

ST Criteria	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
QL Criteria	1 tablet Per 28 months
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actoplus Met

Products Affected

- ACTOPLUS MET

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

Actoplus met XR

Products Affected

- ACTOPLUS MET XR

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

Actos

Products Affected

- ACTOS

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

Adalat CC

Products Affected

- ADALAT CC ORAL TABLET EXTENDED
RELEASE 24 HR* 60 MG

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

Adalat CC

Products Affected

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

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

Adcirca

Products Affected

- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
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

Products Affected

- ADDERALL

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

Adderall XR

Products Affected

- ADDERALL XR

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

Adefovir Dipivoxil

Products Affected

- *adefovir dipivoxil*

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

Adempas

Products Affected

- ADEMPAS

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

Adrenaclick

Products Affected

- ADRENACLICK INJECTION

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

Advair Diskus

Products Affected

- ADVAIR DISKUS INHALATION AEROSOL
POWDER, BREATH ACTIVATED 100-50
MCG/DOSE

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

Advair Diskus

Products Affected

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

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

Advair Diskus

Products Affected

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

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

Advair HFA

Products Affected

- ADVAIR HFA

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

Advate

Products Affected

- ADVATE

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

Advicor

Products Affected

- ADVICOR ORAL TABLET EXTENDED
RELEASE 24 HR* 500-20 MG, 750-20 MG,
1000-40 MG

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

Advicor

Products Affected

- ADVICOR ORAL TABLET EXTENDED
RELEASE 24 HR* 1000-20 MG

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

Adynovate

Products Affected

- *adynovate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: 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
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	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)
Required Medical Information	
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	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AeroChamber MV

Products Affected

- AEROCHAMBER MV

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

Aerospan

Products Affected

- AEROSPAN

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

Afeditab CR

Products Affected

- AFEDITAB CR ORAL TABLET EXTENDED
RELEASE 24 HR* 60 MG

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

Afeditab CR

Products Affected

- AFEDITAB CR ORAL TABLET EXTENDED
RELEASE 24 HR* 30 MG

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

Afinitor

Products Affected

- AFINITOR

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

Afrezza

Products Affected

- AFREZZA INHALATION POWDER 4 (90) & 8 (90) UNIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin (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.
Age Restrictions	
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

Afrezza

Products Affected

- AFREZZA INHALATION POWDER 4 UNIT, 4 (30) & 8 (60) UNIT, 4 (60) & 8 (30) UNIT, 8 (60)& 12 (30) UNIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin (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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Afstyla

Products Affected

- AFSTYLA

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

Akynzeo

Products Affected

- AKYNZEO

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of nausea and vomiting associated with cancer chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Akynzeo will be considered medically necessary for those members who have adocumented chemotherapy regimen that requires more than two cycles of antiemetic per 30 days
QL Criteria	2 capsules Per 1 month
Notes/References	Annual Review: 03/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aldara

Products Affected

- ALDARA

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

Aldurazyme

Products Affected

- ALDURAZYME

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

Alendronate Sodium

Products Affected

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

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

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 35 mg, 70 mg*

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

Alendronate Sodium

Products Affected

- *alendronate sodium oral solution*

QL Criteria	300 ml Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 10 mg*

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

Alfuzosin HCl ER

Products Affected

- *alfuzosin hcl er*

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

Allegra Allergy

Products Affected

- ALLEGRA ALLERGY ORAL TABLET 180 MG

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

Allegra Allergy

Products Affected

- ALLEGRA ALLERGY ORAL TABLET 60 MG

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

Almotriptan Malate

Products Affected

- *almotriptan malate*

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

Alogliptin Benzoate

Products Affected

- *alogliptin benzoate*

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

Alogliptin-Metformin HCl

Products Affected

- *alogliptin-metformin hcl*

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

Alogliptin-Pioglitazone

Products Affected

- *alogliptin-pioglitazone*

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

Alora

Products Affected

- ALORA

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

Alosetron HCl

Products Affected

- *alose tron hcl*

PA Criteria	Criteria Details
Covered Uses	severe diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial of 2 alternatives: diphenoxylate/atropine, loperamide
Notes/References	
Revision Date	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
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AlphaNine SD

Products Affected

- ALPHANINE SD

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

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

Alprolix

Products Affected

- ALPROLIX

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

Altavera

Products Affected

- ALTAVERA

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

Altoprev

Products Affected

- ALTOPREV

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

Alvesco

Products Affected

- ALVESCO

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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

Alyacen 1/35

Products Affected

- *alyacen 1/35*

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

Alyacen 7/7/7

Products Affected

- *alyacen 7/7/7*

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

Ambien

Products Affected

- AMBIEN

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

Ambien CR

Products Affected

- AMBIEN CR

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

Amerge

Products Affected

- AMERGE

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

Amethia

Products Affected

- AMETHIA

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

Amethia Lo

Products Affected

- AMETHIA LO

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

Amethyst

Products Affected

- AMETHYST

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

Amitiza

Products Affected

- AMITIZA

ST Criteria	Documented step through LACTULOSE* OR MIRALAX*
QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amlodipine Besylate-Valsartan

Products Affected

- *amlodipine besylate-valsartan*

ST Criteria	Documented step through AMLODIPINE in combination with TWO of the following (brand or generic if available): ATACAND, AVAPRO, COZAAR, MICARDIS
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amlodipine-Valsartan-HCTZ

Products Affected

- *amlodipine-valsartan-hctz*

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

Amphetamine Salt Combo

Products Affected

- *amphetamine salt combo*

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

Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

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

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine*

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

Ampyra

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
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

Androderm

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24
HR 2 MG/24HR, 4 MG/24HR

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	1 patch Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

Androderm

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24
HR 2.5 MG/24HR, 5 MG/24HR

ST Criteria	A documented step through one month of Androgel 1.62%
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 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
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	2.5 grams Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	5 grams Per 1 day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of AndroGel 1.62%
QL Criteria	10 grams Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1.25 grams Per 1 day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

AndroGel Pump

Products Affected

- ANDROGEL PUMP TRANSDERMAL GEL
12.5 MG/ACT (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	10 grams Per 1 fill
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

AndroGel Pump

Products Affected

- ANDROGEL PUMP TRANSDERMAL GEL
20.25 MG/ACT (1.62%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	5 grams Per 1 fill
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

Angeliq

Products Affected

- ANGELIQ

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

Anoro Ellipta

Products Affected

- ANORO ELLIPTA

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

Antara

Products Affected

- ANTARA ORAL CAPSULE 30 MG, 90 MG

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

Anzemet

Products Affected

- ANZEMET ORAL

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

APAP-Caff-Dihydrocodeine

Products Affected

- *apap-caff-dihydrocodeine oral capsule*

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

Apidra

Products Affected

- APIDRA

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

Apidra SoloStar

Products Affected

- APIDRA SOLOSTAR SUBCUTANEOUS*

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

Apri

Products Affected

- APRI

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

Apriso

Products Affected

- APRISO

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

Aptensio XR

Products Affected

- APTENSIO XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	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)
Required Medical Information	
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	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aptiom

Products Affected

- APTIOM ORAL TABLET 200 MG

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

Aptiom

Products Affected

- APTIOM ORAL TABLET 600 MG

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

Aptiom

Products Affected

- APTIOM ORAL TABLET 800 MG

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

Aptiom

Products Affected

- APTIOM ORAL TABLET 400 MG

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

Aralast NP

Products Affected

- ARALAST NP INTRAVENOUS*
SOLUTION RECONSTITUTED 1000 MG,
500 MG, 800 MG

PA Criteria	Criteria Details
Covered Uses	pending
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	pending
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aranelle

Products Affected

- ARANELLE

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

Aranesp (Albumin Free)

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 10 MCG/0.4ML, 60 MCG/ML, 150 MCG/0.75ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 100 MCG/ML, 200 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION

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

Arava

Products Affected

- ARAVA

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

Arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html
Exclusion Criteria	
Required Medical 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

Arcapta Neohaler

Products Affected

- ARCAPTA NEOHALER

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

Aricept

Products Affected

- ARICEPT

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

ARIPiprazole

Products Affected

- *aripiprazole oral solution*

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

ARIPiprazole

Products Affected

- *aripiprazole oral tablet dispersible*
- *aripiprazole oral tablet*

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

Arixtra

Products Affected

- ARIXTRA

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

Armodafinil

Products Affected

- *armodafinil oral tablet 200 mg, 250 mg, 150 mg*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
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

Armodafinil

Products Affected

- *armodafinil oral tablet 50 mg*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
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

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

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
QL Criteria	1 blister Per 1 Day
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

Products Affected

- ASACOL HD

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

Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 0.5 MG

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

Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 1 MG

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

Atacand

Products Affected

- ATACAND

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

Atacand HCT

Products Affected

- ATACAND HCT

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

Atelvia

Products Affected

- ATELVIA

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

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

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

Atripla

Products Affected

- ATRIPLA

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

Atrovent

Products Affected

- ATROVENT

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

Aubagio

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
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

Avalide

Products Affected

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

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

Avandia

Products Affected

- AVANDIA ORAL TABLET 4 MG, 2 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	1 tab Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avapro

Products Affected

- AVAPRO

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

Aviane

Products Affected

- AVIANE

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

AVINza

Products Affected

- AVINZA

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

Avita

Products Affected

- *avita*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Avodart

Products Affected

- AVODART

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

Avonex

Products Affected

- AVONEX

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

Avonex Pen

Products Affected

- AVONEX PEN INTRAMUSCULAR*

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

Avonex Prefilled

Products Affected

- AVONEX PREFILLED INTRAMUSCULAR*

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

Axert

Products Affected

- AXERT

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

Axiron

Products Affected

- AXIRON

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	6 mL Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Azilect

Products Affected

- AZILECT

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

Azor

Products Affected

- AZOR

ST Criteria	Documented step through amlodipine in combination with TWO of the following: ATACAND*, AVAPRO*, COZAAR*, MICARDIS*
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

Azulfidine

Products Affected

- AZULFIDINE

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

Azulfidine EN-tabs

Products Affected

- AZULFIDINE EN-TABS

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

Azurette

Products Affected

- AZURETTE

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

Balsalazide Disodium

Products Affected

- *balsalazide disodium*

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

Balziva

Products Affected

- BALZIVA

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

Banzel

Products Affected

- BANZEL ORAL TABLET

QL Criteria	8 tabs Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Baraclude

Products Affected

- BARACLUDGE ORAL TABLET

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

Bayer Contour Next Test

Products Affected

- BAYER CONTOUR NEXT TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bayer Contour Test

Products Affected

- BAYER CONTOUR TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bebulin

Products Affected

- BEBULIN

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

Beconase AQ

Products Affected

- BECONASE AQ

ST Criteria	adequate trial of 2 weeks each of 1 of the following: trial of Flonase OR Nasalide OR Nasacort 24HR OTC AND Nasonex
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Belbuca

Products Affected

- BELBUCA

PA Criteria	Criteria Details
Covered Uses	Pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
Exclusion Criteria	Acute or severe bronchial asthma, known or suspected gastrointestinal obstruction, including paralytic ileus
Required Medical Information	(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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 films Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Belsomra

Products Affected

- BELSOMRA

ST Criteria	Trial of 1 month of one preferred generic alternative (zolpidem, zolpidem er, zaleplon)
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

BeneFIX

Products Affected

- BENEFIX INTRAVENOUS* SOLUTION RECONSTITUTED

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

Benicar

Products Affected

- BENICAR

ST Criteria	Documented step through TWO of the following (brand or generic): ATACAND, AVAPRO, COZAAR, MICARDIS
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

Benicar HCT

Products Affected

- BENICAR HCT

ST Criteria	Documented step through TWO of the following: ATACAND HCT*, AVALIDE*, HYZAAR*, MICARDIS HCT*
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benlysta

Products Affected

- BENLYSTA

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

Berinert

Products Affected

- BERINERT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angi_oedema.html
Exclusion Criteria	
Required Medical 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

Betaseron

Products Affected

- BETASERON SUBCUTANEOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
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

Products Affected

- BETHKIS

QL Criteria	224 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bevespi Aerosphere

Products Affected

- BEVESPI AEROSPHERE

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

Beyaz

Products Affected

- BEYAZ

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

Bicalutamide

Products Affected

- *bicalutamide*

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

Bimatoprost

Products Affected

- *bimatoprost ophthalmic*

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

Bivigam

Products Affected

- BIVIGAM

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

Boniva

Products Affected

- BONIVA INTRAVENOUS*

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

Boniva

Products Affected

- BONIVA ORAL TABLET 150 MG

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

Bosulif

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
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

Botox

Products Affected

- BOTOX

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

Breo Ellipta

Products Affected

- BREO ELLIPTA

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

Breo Ellipta

Products Affected

- BREO ELLIPTA

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

Brevicon (28)

Products Affected

- BREVICON (28)

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

Briellyn

Products Affected

- *briellyn*

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

Brilinta

Products Affected

- BRILINTA

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

Brilinta

Products Affected

- BRILINTA

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

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

Brisdelle

Products Affected

- BRISDELLE

PA Criteria	Criteria Details
Covered Uses	Vasomotor symptoms associated with menopause
Exclusion Criteria	
Required Medical Information	Documented diagnosis of moderate to severe vasomotor symptoms associated with menopause
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule 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 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

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trail of one month each of FORADIL AND SEREVENT
QL Criteria	60 vials Per 1 fill
Notes/References	Annual Review: 07/2016
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Budesonide

Products Affected

- *budesonide inhalation*

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	For ages 5-8 documented inability to use metered dose inhalers
Age Restrictions	Less than 8 years of age
Prescriber Restrictions	
Coverage Duration	Up to the age of 8
Other Criteria	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
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 6.3-1 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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	2 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

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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	6 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

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 4.2-0.7 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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 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

Buphenyl

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: 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
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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	24 tabs Per 1 month
Notes/References	Annual Review: 04/2016
Revision Date	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
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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 tablets 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

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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 tabs 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

Buproban

Products Affected

- BUPROBAN

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

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

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

BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

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

BuPROPion HCl ER (XL)

Products Affected

- *bupropion hcl er (xl)*

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

Butorphanol Tartrate

Products Affected

- *butorphanol tartrate nasal*

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

Butrans

Products Affected

- BUTRANS

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

Bydureon

Products Affected

- BYDUREON SUBCUTANEOUS* 2 MG

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

Byetta 10 MCG Pen

Products Affected

- BYETTA 10 MCG PEN SUBCUTANEOUS*

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

Byetta 5 MCG Pen

Products Affected

- BYETTA 5 MCG PEN SUBCUTANEOUS*

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

Bystolic

Products Affected

- BYSTOLIC ORAL TABLET 20 MG

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

Bystolic

Products Affected

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

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

Byvalson

Products Affected

- BYVALSON

PA Criteria	Criteria Details
Covered Uses	Hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through 2 generic beta-blockers and 2 generic angiotensin receptor blockers (ARBs)
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

Cabometyx

Products Affected

- CABOMETYX

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

Calcipotriene

Products Affected

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

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

Calcipotriene-Betameth Diprop

Products Affected

- *calcipotriene-betameth diprop*

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

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

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

Calcitrene

Products Affected

- *calcitrene*

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

Camrese

Products Affected

- CAMRESE

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

Camrese Lo

Products Affected

- CAMRESE LO

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

Canasa

Products Affected

- CANASA

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

Candesartan Cilexetil

Products Affected

- *candesartan cilexetil*

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

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz*

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

Capecitabine

Products Affected

- *capecitabine*

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

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG

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

Carbaglu

Products Affected

- CARBAGLU

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

Cardizem CD

Products Affected

- CARDIZEM CD ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 360 MG,
300 MG, 120 MG, 180 MG

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

Cardizem CD

Products Affected

- CARDIZEM CD ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 240 MG

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

Cardizem LA

Products Affected

- CARDIZEM LA ORAL TABLET
EXTENDED RELEASE 24 HR* 120 MG, 180
MG, 420 MG, 300 MG, 360 MG

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

Cardizem LA

Products Affected

- CARDIZEM LA ORAL TABLET
EXTENDED RELEASE 24 HR* 240 MG

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

Cardura XL

Products Affected

- CARDURA XL

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

Carimune NF

Products Affected

- CARIMUNE NF INTRAVENOUS*
SOLUTION RECONSTITUTED 12 GM, 6
GM

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

Cartia XT

Products Affected

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

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

Cartia XT

Products Affected

- CARTIA XT ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 240 MG

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

Casodex

Products Affected

- CASODEX

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

Cayston

Products Affected

- CAYSTON

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

Caziant

Products Affected

- CAZIAN T

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

CeleBREX

Products Affected

- CELEBREX

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

Celecoxib

Products Affected

- *celecoxib oral*

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

CeleXA

Products Affected

- CELEXA ORAL TABLET

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

Cenestin

Products Affected

- CENESTIN ORAL TABLET 0.3 MG

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

Cerdelga

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 2 dayss
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cerezyme

Products Affected

- CERZYME INTRAVENOUS* SOLUTION
RECONSTITUTED 400 UNIT

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

Cesamet

Products Affected

- CESAMET

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

Chantix

Products Affected

- CHANTIX

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

Chantix Continuing Month Pak

Products Affected

- CHANTIX CONTINUING MONTH PAK

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

Chantix Starting Month Pak

Products Affected

- CHANTIX STARTING MONTH PAK

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

Chateal

Products Affected

- CHATEAL

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

Chenodal

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Covered Uses	For treatment of cholesterol-type gallstones in patients over 18 years of age and have tried and failed 2 years of generic Actigall (ursodiol) therapy and are not able to undergo surgery due to systemic disease or age, and for treatment of diagnosed Cerebrotendinous Xanthomatosis (CTX) in patients over 18 years of age
Exclusion Criteria	Intrahepatic duct calculus, Chronic constipation in patients with cholesterol gallstones, Prophylaxis of recurrent gallstones, Hyperlipidemia, Rheumatoid Arthritis
Required Medical Information	Prior to initial coverage for gallstone disease, a cholecystogram or other appropriate imaging studies is required to determine presence of radiolucent gallstones, stones that are transparent to x-rays. Due to high risk of hepatotoxicity and adverse effects, for the first 3 months, authorization is required each month pending hepatic function tests (for both gallstones and CTX). After initial 3 months, authorization required every 3 months for length of treatment, pending hepatic function tests. At 6 months prior to authorization, the following results are required, serum cholesterol levels, hepatic function test, and cholecystogram (monitor dissolution of stones). Safety of use beyond a total of 24 months has not been established
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month (initial authorization), 3 month (reauthorization)
Other Criteria	Max authorization up to 2 years
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cholbam

Products Affected

- CHOLBAM

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

Cialis

Products Affected

- CIALIS ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	diagnosis of benign prostatic hyperplasia
Exclusion Criteria	Erectile dysfunction (ED) diagnosis is not covered except for members with ED benefit rider or Fully Insured (FI) members in the state of NY.
Required Medical Information	A documented diagnosis of diagnosis of benign prostatic hyperplasia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (30 tablets every 30 days)
Other Criteria	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).
QL Criteria	1 tablets Per 1 day
Notes/References	Annual Review: 07/2016
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cialis

Products Affected

- CIALIS ORAL TABLET 2.5 MG

PA Criteria	Criteria Details
Covered Uses	diagnosis of benign prostatic hyperplasia
Exclusion Criteria	Erectile dysfunction (ED) diagnosis is not covered except for members with ED benefit rider or Fully Insured (FI) members in the state of NY.
Required Medical Information	A documented diagnosis of diagnosis of benign prostatic hyperplasia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (30 tablets every 30 days)
Other Criteria	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).
QL Criteria	1 tablets Per 1 day
Notes/References	
Revision Date	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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
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

Products Affected

- CIMZIA STARTER KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
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

Cinqair

Products Affected

- CINQAIR

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

Cinryze

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angi_oedema.html
Exclusion Criteria	
Required Medical 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

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet*

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

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet*

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

Claravis

Products Affected

- *claravis*

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	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.
ST Criteria	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
QL Criteria	2 capsules Per 1 day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarinet

Products Affected

- CLARINEX ORAL TABLET

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

Clarinet-D 12 Hour

Products Affected

- CLARINEX-D 12 HOUR

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

Climara

Products Affected

- CLIMARA

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

Climara Pro

Products Affected

- CLIMARA PRO

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

CloNIDine HCl ER

Products Affected

- *clonidine hcl er*

PA Criteria	Criteria Details
Covered Uses	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.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	4 tabs Per 1 day
Notes/References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate*

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

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate*

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 200 mg*

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

Clozaril

Products Affected

- CLOZARIL ORAL TABLET 25 MG

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

Clozaril

Products Affected

- CLOZARIL ORAL TABLET 100 MG

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

Coagadex

Products Affected

- COAGADEX

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

Colazal

Products Affected

- COLAZAL

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

Colchicine

Products Affected

- *colchicine oral tablet*

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

Colcrlys

Products Affected

- COLCRYS

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

Colyte with Flavor Packs

Products Affected

- COLYTE WITH FLAVOR PACKS ORAL SOLUTION RECONSTITUTED 240 GM

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

CombiPatch

Products Affected

- COMBIPATCH

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

Cometriq (100 mg Daily Dose)

Products Affected

- COMETRIQ (100 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 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)

Products Affected

- COMETRIQ (140 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 kit 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)

Products Affected

- COMETRIQ (60 MG DAILY DOSE)

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

Complera

Products Affected

- COMPLERA

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

Concerta

Products Affected

- CONCERTA ORAL TABLET
EXTENDEDRELEASE* 27 MG, 18 MG, 54
MG

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

Concerta

Products Affected

- CONCERTA ORAL TABLET
EXTENDEDRELEASE* 36 MG

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

Copaxone

Products Affected

- COPAXONE SUBCUTANEOUS* 40 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical 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

Copaxone

Products Affected

- COPAXONE SUBCUTANEOUS* 20 MG/ML

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

Cordran

Products Affected

- CORDRAN EXTERNAL TAPE

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

Coreg CR

Products Affected

- COREG CR

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

Corifact

Products Affected

- CORIFACT

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

Corlanor

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	FDA labeled use for heart failure
Exclusion Criteria	
Required Medical Information	Documentation of stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater 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, nevigolol) or have a documented contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Have a 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
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: July 25, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cosentyx

Products Affected

- COSENTYX

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

Cosentyx Sensoready Pen

Products Affected

- COSENTYX SENSOREADY PEN
SUBCUTANEOUS* 150 MG/ML

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

Cozaar

Products Affected

- COZAAR ORAL TABLET 50 MG, 25 MG

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

Crestor

Products Affected

- CRESTOR

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

Cryselle-28

Products Affected

- CRYSELLE-28

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

Cuprimine

Products Affected

- CUPRIMINE ORAL CAPSULE 250 MG

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

Cuvitru

Products Affected

- CUVITRU

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

Cyclafem 1/35

Products Affected

- CYCLAFEM 1/35

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

Cyclessa

Products Affected

- CYCLESSA

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

Cycloset

Products Affected

- CYCLOSET

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

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED
RELEASE PARTICLES 20 MG

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

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED
RELEASE PARTICLES 60 MG

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

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED
RELEASE PARTICLES 30 MG

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

Cystadane

Products Affected

- CYSTADANE

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

Cystagon

Products Affected

- CYSTAGON

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

Cystaran

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 bottles Per 1 month
Notes/References	
Revision Date	Prior Authorization: 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: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
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

Daklinza

Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
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

Daliresp

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	Severe COPD (GOLD stage 3 or 4)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of severe (Stage III) or very severe (StageIV) chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and a history of exacerbations
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial of 2 preferred alternatives: Dulera, Symbicort, Spiriva, Incruse, Anoro, or Stiolto
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

Darifenacin Hydrobromide ER

Products Affected

- *darifenacin hydrobromide er*

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

Dasetta 1/35

Products Affected

- DASETTA 1/35

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

Dasetta 7/7/7

Products Affected

- DASETTA 7/7/7

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

Daysee

Products Affected

- DAYSEE

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

Daytrana

Products Affected

- DAYTRANA

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

Delzicol

Products Affected

- DELZICOL

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

Depen Titratabs

Products Affected

- DEPEN TITRATABS

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

Depo-Provera

Products Affected

- DEPO-PROVERA INTRAMUSCULAR*
SUSPENSION 150 MG/ML

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

Depo-SubQ Provera 104

Products Affected

- DEPO-SUBQ PROVERA 104
SUBCUTANEOUS* SUSPENSION

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

Descovy

Products Affected

- DESCOVY

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

Desloratadine

Products Affected

- *desloratadine*

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

Desogen

Products Affected

- DESOGEN

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

Desogestrel-Ethinyl Estradiol

Products Affected

- *desogestrel-ethinyl estradiol oral tablet*
0.15-30 mg-mcg

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

Desoxyn

Products Affected

- DESOXYN

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 tabs Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desvenlafaxine ER

Products Affected

- *desvenlafaxine er*

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

Desvenlafaxine Fumarate ER

Products Affected

- *desvenlafaxine fumarate er*

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

Detrol LA

Products Affected

- DETROL LA

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

Dexedrine

Products Affected

- DEXEDRINE ORAL TABLET

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	
Notes/ References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexedrine

Products Affected

- DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR

PA Criteria	Criteria Details
Covered Uses	Attention deficit disorder, Attention deficit hyperactivity disorder
Exclusion Criteria	
Required Medical Information	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.
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	3 caps Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 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	
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

Products Affected

- *dexmethylphenidate hcl*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

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

Dextroamphetamine Sulfate

Products Affected

- dextroamphetamine sulfate oral tablet*

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	
QL Criteria	4 tabs Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dextroamphetamine Sulfate ER

Products Affected

- dextroamphetamine sulfate er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit disorder, Attention deficit hyperactivity disorder
Exclusion Criteria	
Required Medical Information	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.
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	3 caps Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diastat AcuDial

Products Affected

- DIASTAT ACUDIAL

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

Diastat Pediatric

Products Affected

- DIASTAT PEDIATRIC

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

Diazepam

Products Affected

- *diazepam gel*

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

Dibenzyline

Products Affected

- DIBENZYLINE

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

Diclegis

Products Affected

- DICLEGIS

QL Criteria	60 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal solution*

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

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 1 %*

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

Differin

Products Affected

- DIFFERIN EXTERNAL LOTION
- DIFFERIN EXTERNAL GEL

ST Criteria	Documented step through RETIN-A*
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dificid

Products Affected

- DIFICID

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

Dihydroergotamine Mesylate

Products Affected

- *dihydroergotamine mesylate nasal*

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

Diltiazem HCl ER

Products Affected

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

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

Diltiazem HCl ER Beads

Products Affected

- diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 300 mg, 360 mg, 180 mg*

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Coated Beads

Products Affected

- diltiazem hcl er coated beads oral capsule
extended release 24 hour 300 mg, 120 mg, 180
mg, 360 mg*

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

Diltiazem HCl ER Coated Beads

Products Affected

- diltiazem hcl er coated beads oral tablet
extended release 24 hr* 360 mg, 420 mg, 180
mg, 300 mg*

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

Diltiazem HCl ER Coated Beads

Products Affected

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

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

Diltiazem HCl ER Coated Beads

Products Affected

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

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

Diovan

Products Affected

- DIOVAN

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

Diovan HCT

Products Affected

- DIOVAN HCT

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

Dipentum

Products Affected

- DIPENTUM

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

Ditropan XL

Products Affected

- DITROPAN XL ORAL TABLET
EXTENDED RELEASE 24 HR* 10 MG, 15
MG

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

Ditropan XL

Products Affected

- DITROPAN XL ORAL TABLET
EXTENDED RELEASE 24 HR* 5 MG

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

Dolophine

Products Affected

- DOLOPHINE

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

Donepezil HCl

Products Affected

- *donepezil hcl*

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

Doryx MPC

Products Affected

- DORYX MPC

ST Criteria	A documented step through 1 of the following: minocycline caps 50mg, 75mg, or 100mg, doxycycline monohydrate caps 50mg or 100mg, doxycycline hyclate caps 50mg or 100mg, or doxycycline hyclate tabs 100mg
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dovonex

Products Affected

- DOVONEX EXTERNAL CREAM

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

Doxycycline

Products Affected

- *doxycycline*

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

Dronabinol

Products Affected

- *dronabinol*

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

Drospirenone-Ethinyl Estradiol

Products Affected

- *drospirenone-ethinyl estradiol oral tablet*
3-0.03 mg

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

Duavee

Products Affected

- DUAVEE

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

Duetact

Products Affected

- DUETACT

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

Duexis

Products Affected

- DUEXIS

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

Dulera

Products Affected

- DULERA

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

DULoxetine HCl

Products Affected

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

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

DULoxetine HCl

Products Affected

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

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

DULoxetine HCl

Products Affected

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

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

Duragesic-100

Products Affected

- DURAGESIC-100

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

Duragesic-12

Products Affected

- DURAGESIC-12

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

Duragesic-25

Products Affected

- DURAGESIC-25

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

Duragesic-50

Products Affected

- DURAGESIC-50

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

Duragesic-75

Products Affected

- DURAGESIC-75

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

Dutasteride

Products Affected

- *dutasteride*

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

Dyanavel XR

Products Affected

- DYANAVEL XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	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)
Required Medical Information	
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	240 ML Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dysport

Products Affected

- DYSPOORT

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

Edarbi

Products Affected

- EDARBI

ST Criteria	Documented step through TWO of the following (brand or generic): ATACAND, AVAPRO, COZAAR, MICARDIS
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Edarbyclor

Products Affected

- EDARBYCLOR

ST Criteria	Documented step through TWO of the following: ATACAND HCT*, AVALIDE*, HYZAAR*, MICARDIS HCT*
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Edurant

Products Affected

- EDURANT

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

Effexor XR

Products Affected

- EFFEXOR XR

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

Effient

Products Affected

- EFFIENT

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI].
Exclusion Criteria	History of Stroke or TIA
Required Medical Information	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)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tab Per 1 day
Notes/References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elaprase

Products Affected

- ELAPRASE

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

Elelyso

Products Affected

- ELELYSO

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

Elestrin

Products Affected

- ELESTRIN

QL Criteria	52 gm Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elidel

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition
Notes/References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eligard

Products Affected

- ELIGARD

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

Elinest

Products Affected

- ELINEST

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

Ella

Products Affected

- ELLA

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

Eloctate

Products Affected

- ELOCTATE

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

Embeda

Products Affected

- EMBEDA

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	2 capsules 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

Emend

Products Affected

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

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

Emend

Products Affected

- EMEND ORAL CAPSULE 80 & 125 MG

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

EMLA

Products Affected

- EMLA

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, Sensitivity to amide-type local anesthetics or any other component of the product, Planned use on large surface area of the body or for a period of time over 3 hours as this can lead to increased toxicity, the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), Use in situations where the drug may migrate into the middle ear, beyond the tympanic membrane, History of methemoglobinemia, or if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	*Topical lidocaine/prilocaine cream is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Up to an additional 30 grams per 30 days. Higher additional quantities are not approvable.
QL Criteria	30 GM Per 30 Days
Notes/References	

Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	--

Emoquette

Products Affected

- EMOQUETTE

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

Emsam

Products Affected

- EMSAM

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

Emtriva

Products Affected

- EMTRIVA ORAL CAPSULE

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

Enablex

Products Affected

- ENABLEX

ST Criteria	Documented trial of 2 preferred alternatives: Vesicare OR Myrbetriq AND one generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
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

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS* 50 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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

Products Affected

- ENBREL SUBCUTANEOUS* 25 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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 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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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

Products Affected

- ENJUVIA

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

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium*

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

Enpresse-28

Products Affected

- ENPRESSE-28

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

Enskyce

Products Affected

- ENSKYCE

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

Entecavir

Products Affected

- *entecavir*

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

Entresto

Products Affected

- ENTRESTO

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

Entyvio

Products Affected

- ENTYVIO

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

Epaned

Products Affected

- EPANED

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

Epclusa

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2016/GI/hepatitis_c.html
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

Epiduo

Products Affected

- EPIDUO

ST Criteria	Documented step through RETIN-A*
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EPINEPHrine

Products Affected

- *epinephrine injection 0.15 mg/0.15ml*

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

EPINEPHrine

Products Affected

- *epinephrine injection 0.3 mg/0.3ml*

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

EpiPen 2-Pak

Products Affected

- EPIPEN 2-PAK INJECTION

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

EpiPen Jr 2-Pak

Products Affected

- EPIPEN JR 2-PAK INJECTION

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

Epogen

Products Affected

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

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

Epoprostenol Sodium

Products Affected

- *epoprostenol sodium*

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

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

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

Erivedge

Products Affected

- ERIVEDGE

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

Errin

Products Affected

- ERRIN

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

Esbriet

Products Affected

- ESBRIET

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

Escitalopram Oxalate

Products Affected

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

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

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

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium*

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

Estarylla

Products Affected

- ESTARYLLA

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

Estradiol

Products Affected

- *estradiol transdermal patch biweekly*

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

Estradiol

Products Affected

- *estradiol transdermal patch weekly*

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

Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

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

Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

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

Estrogel

Products Affected

- ESTROGEL

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

Estrostep Fe

Products Affected

- ESTROSTEP FE

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

Eszopiclone

Products Affected

- *eszopiclone*

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

Euflexxa

Products Affected

- EUFLEXXA INTRA-ARTICULAR*

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

Evamist

Products Affected

- EVAMIST

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

Evekeo

Products Affected

- EVEKEO

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

Evoxac

Products Affected

- EVOXAC

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

Exalgo

Products Affected

- EXALGO ORAL 32 MG, 12 MG, 8 MG

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

Exalgo

Products Affected

- EXALGO ORAL 16 MG

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

Exelon

Products Affected

- EXELON ORAL CAPSULE
- EXELON TRANSDERMAL

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

Exforge

Products Affected

- EXFORGE ORAL TABLET 10-320 MG,
5-320 MG

ST Criteria	Documented step through AMLODIPINE in combination with TWO of the following (brand or generic if available): ATACAND, AVAPRO, COZAAR, MICARDIS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exforge

Products Affected

- EXFORGE ORAL TABLET 5-160 MG,
10-160 MG

ST Criteria	Documented step through AMLODIPINE in combination with TWO of the following (brand or generic if available): ATACAND, AVAPRO, COZAAR, MICARDIS
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exforge HCT

Products Affected

- EXFORGE HCT

ST Criteria	2 of the following (brand or generic if available): Atacand HCT*, Avalide*, Hyzaar*, Micardis HCT*
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exjade

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: 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: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
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

Eylea

Products Affected

- EYLEA

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

Fabior

Products Affected

- FABIOR

ST Criteria	Documented step through RETIN-A*
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fabrazyme

Products Affected

- FABRAZYME

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

Falmina

Products Affected

- FALMINA

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

Famciclovir

Products Affected

- *famciclovir oral*

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

Famvir

Products Affected

- FAMVIR

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

Fanapt

Products Affected

- FANAPT

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

Fanapt Titration Pack

Products Affected

- FANAPT TITRATION PACK

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	8 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Farxiga

Products Affected

- FARXIGA

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

Farydak

Products Affected

- FARYDAK

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

Faslodex

Products Affected

- FASLODEX INTRAMUSCULAR*
SOLUTION 250 MG/5ML

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
200 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
25 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
100 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
12.5 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
150 MG

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

Feiba

Products Affected

- FEIBA

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

Felodipine ER

Products Affected

- *felodipine er*

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

Femcon Fe

Products Affected

- FEMCON FE

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

Femhrt Low Dose

Products Affected

- FEMHRT LOW DOSE

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

Femring

Products Affected

- FEMRING

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

Fenofibric Acid

Products Affected

- *fenofibric acid oral capsule delayed release*

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

Fenoglide

Products Affected

- FENOGLIDE

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

FentaNYL

Products Affected

- *fentanyl transdermal patch 72 hr 100 mcg/hr, 50 mcg/hr, 25 mcg/hr, 12 mcg/hr, 75 mcg/hr*

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

FentaNYL

Products Affected

- *fentanyl transdermal patch 72 hr 37.5 mcg/hr, 87.5 mcg/hr, 62.5 mcg/hr*

QL Criteria	20 patches Per 30 Days
Notes/ References	
Revision Date	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
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A. Documentation of already receiving and who are tolerant to opioid therapy, and documentation on intolerance of two (2) other immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	FOR SUBSYS: Documentation of intolerance to Actiq. FOR ABSTRAL, FENTORA, LAZANDA, and ONSOLIS: Documentation of intolerance to Actiq AND Subsys.
ST Criteria	Documented trial or intolerance to two (2) immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone
QL Criteria	4 lozenge Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fentora

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))
ST Criteria	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
QL Criteria	4 tabs Per 1 day

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

Notes/ References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ferriprox

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: 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	
QL Criteria	1 cap Per 1 Day
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	
QL Criteria	1 cap Per 1 Day
Notes/References	Annual Review: 05/2016
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fibricor

Products Affected

- FIBRICOR

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

Firazyr

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angi_oedema.html
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 syringes Per 1 fill
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Firmagon

Products Affected

- FIRMAGON

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

Flebogamma DIF

Products Affected

- FLEBOGAMMA DIF INTRAVENOUS*
SOLUTION 20 GM/400ML, 5 GM/100ML, 5 GM/50ML, 2.5 GM/50ML, 10 GM/200ML, 0.5 GM/10ML

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

Flolan

Products Affected

- FLOLAN

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

Flovent Diskus

Products Affected

- FLOVENT DISKUS INHALATION
AEROSOL POWDER, BREATH
ACTIVATED 50 MCG/BLIST, 250
MCG/BLIST

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

Flovent Diskus

Products Affected

- FLOVENT DISKUS INHALATION
AEROSOL POWDER, BREATH
ACTIVATED 100 MCG/BLIST

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 inhalers Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flovent HFA

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
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

Fluocinonide

Products Affected

- *fluocinonide external cream*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 60 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 40 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

Fluvastatin Sodium ER

Products Affected

- *fluvastatin sodium er*

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

FluvoxaMINE Maleate

Products Affected

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

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

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

Fluvoxamine Maleate ER

Products Affected

- *fluvoxamine maleate er*

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

Focalin

Products Affected

- FOCALIN

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

Focalin XR

Products Affected

- FOCALIN XR

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

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium*

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

Foradil Aerolizer

Products Affected

- FORADIL AEROLIZER

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

Forteo

Products Affected

- FORTEO SUBCUTANEOUS* SOLUTION
600 MCG/2.4ML

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

Fortesta

Products Affected

- FORTESTA

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	4 grams Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fortical

Products Affected

- FORTICAL

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

Fosamax

Products Affected

- FOSAMAX ORAL TABLET 70 MG

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

Fosamax Plus D

Products Affected

- FOSAMAX PLUS D

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

Fragmin

Products Affected

- FRAGMIN SUBCUTANEOUS* SOLUTION
15000 UNIT/0.6ML, 18000 UNT/0.72ML,
5000 UNIT/0.2ML, 95000 UNIT/3.8ML,
10000 UNIT/ML, 12500 UNIT/0.5ML, 2500
UNIT/0.2ML, 7500 UNIT/0.3ML

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

FreeStyle InsuLinx Test

Products Affected

- FREESTYLE INSULINX TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FreeStyle Lite Test

Products Affected

- FREESTYLE LITE TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FreeStyle Test

Products Affected

- FREESTYLE TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Frova

Products Affected

- FROVA

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

Frovatriptan Succinate

Products Affected

- *frovatriptan succinate*

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

Fuzeon

Products Affected

- FUZEON SUBCUTANEOUS* SOLUTION RECONSTITUTED

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

Fycompa

Products Affected

- FYCOMPA ORAL TABLET

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

Gabapentin

Products Affected

- *gabapentin oral tablet*

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

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gabapentin

Products Affected

- *gabapentin oral solution 250 mg/5ml*

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

Gabril

Products Affected

- GABITRIL ORAL TABLET 4 MG, 12 MG

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

Gabitril

Products Affected

- GABITRIL ORAL TABLET 16 MG

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

Gabitril

Products Affected

- GABITRIL ORAL TABLET 2 MG

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

Galantamine Hydrobromide

Products Affected

- *galantamine hydrobromide*

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

Products Affected

- GAMMAGARD

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

Gammagard S/D Less IgA

Products Affected

- GAMMAGARD S/D LESS IGA

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

Gammaked

Products Affected

- GAMMAKED

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

Gammaplex

Products Affected

- GAMMAPLEX INTRAVENOUS*
SOLUTION 5 GM/100ML, 10 GM/200ML, 20
GM/400ML

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

Gamunex-C

Products Affected

- GAMUNEX-C

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

Gelnique

Products Affected

- GELNIQUE

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

Gel-One

Products Affected

- GEL-ONE INTRA-ARTICULAR*

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

Gelsyn-3

Products Affected

- GELSYN-3

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

Generess FE

Products Affected

- GENERESS FE

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

Genotropin

Products Affected

- GENOTROPIN

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

Genotropin MiniQuick

Products Affected

- GENOTROPIN MINIQUICK

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

Genvoya

Products Affected

- GENVOYA

PA Criteria	Criteria Details
Covered Uses	Human Immunodeficiency Virus (HIV)
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, extended approval upon Review every 1 year meeting the following criteria: A documented
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Geodon

Products Affected

- GEODON ORAL

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

Gianvi

Products Affected

- GIANVI

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

Giazo

Products Affected

- GIAZO

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

Gildagia

Products Affected

- GILDAGIA

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

Gildess FE 1.5/30

Products Affected

- GILDESS FE 1.5/30

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

Gildess FE 1/20

Products Affected

- GILDESS FE 1/20

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

Gilenya

Products Affected

- GILENYA

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

Gilotrif

Products Affected

- GILOTRIF

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

Glassia

Products Affected

- GLASSIA

PA Criteria	Criteria Details
Covered Uses	pending
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	pending
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glatopa

Products Affected

- GLATOPA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical 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

Gleevec

Products Affected

- GLEEVEC ORAL TABLET 100 MG

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

GlucaGen HypoKit

Products Affected

- GLUCAGEN HYPOKIT

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

Glyxambi

Products Affected

- GLYXAMBI

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

Gralise

Products Affected

- GRALISE ORAL TABLET 300 MG

QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise

Products Affected

- GRALISE ORAL TABLET 600 MG

QL Criteria	3 tabs Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise Starter

Products Affected

- GRALISE STARTER

QL Criteria	1 pack Per 1 fill
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Granix

Products Affected

- GRANIX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GuanFACINE HCl ER

Products Affected

- *guanfacine hcl er*

PA Criteria	Criteria Details
Covered Uses	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.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	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
Notes/References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Harvoni

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

Helixate FS

Products Affected

- HELIXATE FS

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

Hemangeol

Products Affected

- HEMANGEOL

PA Criteria	Criteria Details
Covered Uses	infantile hemangioma
Exclusion Criteria	
Required Medical Information	(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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hemofil M

Products Affected

- HEMOFIL M INTRAVENOUS* SOLUTION
RECONSTITUTED 1000 UNIT, 1700 UNIT,
500 UNIT, 250 UNIT

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

Hepsera

Products Affected

- HEPSERA

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

Hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	Non-24 sleep wake-disorder
Exclusion Criteria	Documentation of concomitant sleep disorders (sleep apnea, insomnia)
Required Medical Information	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 daytime sleepiness.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: October 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hizentra

Products Affected

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

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

Horizant

Products Affected

- HORIZANT ORAL TABLET
EXTENDEDRELEASE* 300 MG

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Horizant

Products Affected

- HORIZANT ORAL TABLET
EXTENDEDRELEASE* 600 MG

QL Criteria	1 tablet Per 2 Days
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HP Acthar

Products Affected

- HP ACTHAR

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

Humate-P

Products Affected

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

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

Humatrope

Products Affected

- HUMATROPE

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

Humira

Products Affected

- HUMIRA SUBCUTANEOUS* 20 MG/0.4ML, 10 MG/0.2ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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 months
Notes/References	
Revision Date	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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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

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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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

Humira Pen-Crohns Starter

Products Affected

- HUMIRA PEN-CROHNS STARTER
SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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

Products Affected

- HUMIRA PEN-PSORIASIS STARTER
SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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

Products Affected

- HYALGAN

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

Hycamtin

Products Affected

- HYCAMTIN ORAL

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

HYDRomorphone HCl ER

Products Affected

- *hydromorphone hcl er oral 12 mg, 8 mg, 32 mg*

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

HYDRomorphone HCl ER

Products Affected

- *hydromorphone hcl er oral 16 mg*

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

Hymovis

Products Affected

- HYMOVIS

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

Hyqvia

Products Affected

- HYQVIA

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

Hysingla ER

Products Affected

- HYSINGLA ER

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

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

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

Ibandronate Sodium

Products Affected

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

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

Ibrance

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	21 capsules Per 28 Days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 15 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
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

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 45 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
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

Idelvion

Products Affected

- IDELVION

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

Ilaris

Products Affected

- ILARIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html
Exclusion Criteria	
Required Medical 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

Imatinib Mesylate

Products Affected

- *imatinib mesylate*

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

Imiquimod

Products Affected

- *imiquimod external*

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

Imitrex

Products Affected

- IMITREX NASAL

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

Imitrex

Products Affected

- IMITREX SUBCUTANEOUS*

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

Imitrex

Products Affected

- IMITREX ORAL

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

Imitrex STATdose Refill

Products Affected

- IMITREX STATDOSE REFILL
SUBCUTANEOUS*

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

Impavido

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Covered Uses	Leishmaniasis
Exclusion Criteria	Known or suspected pregnancy
Required Medical Information	A documented diagnosis of any of the following leishmaniasis infections: Visceral leishmaniasis due to <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>
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	28 days
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 16, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Increlex

Products Affected

- INCRELEX

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

Incruse Ellipta

Products Affected

- INCRUSE ELLIPTA

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

Inlyta

Products Affected

- INLYTA

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

InnoPran XL

Products Affected

- INNOPRAN XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 80 MG

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

InnoPran XL

Products Affected

- INNOPRAN XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 120 MG

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

Intelligence

Products Affected

- INTELENCE ORAL TABLET 100 MG, 25 MG

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

Intelligence

Products Affected

- INTELENCE ORAL TABLET 200 MG

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

Intermezzo

Products Affected

- INTERMEZZO

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

Intron A

Products Affected

- INTRON A

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

Introvale

Products Affected

- INTROVALE

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

Intuniv

Products Affected

- INTUNIV

PA Criteria	Criteria Details
Covered Uses	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.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	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
QL Criteria	1 tab Per 1 day
Notes/References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED
RELEASE 24 HR* 6 MG, 3 MG, 1.5 MG

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

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED
RELEASE 24 HR* 9 MG

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

Invokamet

Products Affected

- INVOKAMET

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

Invokamet XR

Products Affected

- INVOKAMET XR

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

Invokana

Products Affected

- INVOKANA

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

Ipratropium Bromide

Products Affected

- *ipratropium bromide nasal*

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

Iprivask

Products Affected

- IPRIVASK

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

Irbesartan

Products Affected

- *irbesartan*

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

Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide*

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

Irenka

Products Affected

- IRENKA

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

Iressa

Products Affected

- IRESSA

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET CHEWABLE

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

Itraconazole

Products Affected

- *itraconazole oral*

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

Ixinity

Products Affected

- IXINITY

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

Jadenu

Products Affected

- JADENU

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: 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

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

Jakafi

Products Affected

- JAKAFI ORAL TABLET 10 MG

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

Janumet

Products Affected

- JANUMET

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

Janumet XR

Products Affected

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

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

Janumet XR

Products Affected

- JANUMET XR ORAL TABLET EXTENDED
RELEASE 24 HR* 50-1000 MG

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

Januvia

Products Affected

- JANUVIA

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

Jardiance

Products Affected

- JARDIANCE

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

Jencycla

Products Affected

- JENCYCLA

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

Jentaduetto

Products Affected

- JENTADUETO

ST Criteria	Trial and failure of 1 month each of (a) Januvia, Janumet, or Janumet XR, and (b) Onglyza or Kombiglyze XR
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jentaduetto XR

Products Affected

- JENTADUETO XR ORAL TABLET
EXTENDED RELEASE 24 HR* 5-1000 MG

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

Jentaduetto XR

Products Affected

- JENTADUETO XR ORAL TABLET
EXTENDED RELEASE 24 HR* 2.5-1000 MG

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

Jetrea

Products Affected

- JETREA

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

Jolessa

Products Affected

- JOLESSA

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

Jolivette

Products Affected

- JOLIVETTE

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

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

Products Affected

- JUNEL 1.5/30

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

Junel 1/20

Products Affected

- JUNEL 1/20

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

Junel FE 1.5/30

Products Affected

- JUNEL FE 1.5/30

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

Junel FE 1/20

Products Affected

- JUNEL FE 1/20

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

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/AntilipidemicAgents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Antilipidemic%20Agents_HOFH.html
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 20 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/AntilipidemicAgents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Antilipidemic%20Agents_HOFH.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 40 MG, 30 MG, 60 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/AntilipidemicAgents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Antilipidemic%20Agents_HOFH.html
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kadian

Products Affected

- KADIAN

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

Kadian

Products Affected

- KADIAN

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

Kalbitor

Products Affected

- KALBITOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angi_oedema.html
Exclusion Criteria	
Required Medical 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

Kalydeco

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kalydeco

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 packets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kanuma

Products Affected

- KANUMA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: 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
Covered Uses	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.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	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
QL Criteria	4 tabs Per 1 day
Notes/References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kariva

Products Affected

- KARIVA

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

Kazano

Products Affected

- KAZANO

ST Criteria	Documented step through 1 month each of 2 preferred alternatives: Januvia and Onglyza (single entity or combination)
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kcentra

Products Affected

- KCENTRA

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

Kelnor 1/35

Products Affected

- KELNOR 1/35

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

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED
RELEASE 24 HR* 500 MG

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

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED
RELEASE 24 HR* 750 MG

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

Kerydin

Products Affected

- KERYDIN

PA Criteria	Criteria Details
Covered Uses	onychomycosis
Exclusion Criteria	
Required Medical Information	(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

Ketek

Products Affected

- KETEK

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

Ketoconazole

Products Affected

- *ketoconazole oral*

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

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

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

Keveyis

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/carbonic_anhydrase_inhibitor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Khedezla

Products Affected

- KHEDEZLA

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

Kineret

Products Affected

- KINERET SUBCUTANEOUS*

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

Koate-DVI

Products Affected

- KOATE-DVI

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

Kogenate FS

Products Affected

- KOGENATE FS

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

Kogenate FS Bio-Set

Products Affected

- KOGENATE FS BIO-SET

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

Kombiglyze XR

Products Affected

- KOMBIGLYZE XR ORAL TABLET
EXTENDED RELEASE 24 HR* 2.5-1000 MG

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

Kombiglyze XR

Products Affected

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

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

Korlym

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/antidiabetic%20agents.html
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: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kovaltry

Products Affected

- KOVALTRY

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

Krystexxa

Products Affected

- KRYSTEXXA

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

Kurvelo

Products Affected

- KURVELO

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

Kuvan

Products Affected

- KUVAN

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

Kynamro

Products Affected

- KYNAMRO SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/AntilipidemicAgents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Antilipidemic%20Agents_HOFH.html
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET
DISPERSIBLE 200 MG

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET
DISPERSIBLE 100 MG

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET
DISPERSIBLE 25 MG

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET
DISPERSIBLE 50 MG

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

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET
EXTENDED RELEASE 24 HR* 300 MG

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

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET
EXTENDED RELEASE 24 HR* 100 MG, 25
MG, 50 MG

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

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET
EXTENDED RELEASE 24 HR* 250 MG

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

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET
EXTENDED RELEASE 24 HR* 200 MG

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

LamISIL

Products Affected

- LAMISIL ORAL PACKET 125 MG

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

LamISIL

Products Affected

- LAMISIL ORAL PACKET 187.5 MG

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

LamoTRIGine

Products Affected

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

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

LamoTRIGine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

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

LamoTRIGine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

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

LamoTRIGine ER

Products Affected

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

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

LamoTRIGine ER

Products Affected

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

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

LamoTRIGine ER

Products Affected

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

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

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release 15 mg*

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

Lantus

Products Affected

- LANTUS

ST Criteria	A documented step through one month of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lantus SoloStar

Products Affected

- LANTUS SOLOSTAR SUBCUTANEOUS*

ST Criteria	A documented step through one month of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Latuda

Products Affected

- LATUDA ORAL TABLET 80 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
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

Latuda

Products Affected

- LATUDA ORAL TABLET 20 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Latuda

Products Affected

- LATUDA ORAL TABLET 120 MG, 40 MG

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

Latuda

Products Affected

- LATUDA ORAL TABLET 60 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lazanda

Products Affected

- LAZANDA NASAL SOLUTION 100 MCG/ACT, 400 MCG/ACT

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))
ST Criteria	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
QL Criteria	15 bottles Per 1 fill

Notes/ References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lazanda

Products Affected

- LAZANDA NASAL SOLUTION 300 MCG/ACT

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))
QL Criteria	4 bottles Per 30 days
Notes/References	

Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	--

Leena

Products Affected

- LEENA

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

Leflunomide

Products Affected

- *leflunomide oral*

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

Lemtrada

Products Affected

- LEMTRADA

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

Lenvima 10 MG Daily Dose

Products Affected

- LENVIMA 10 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 fill
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lenvima 14 MG Daily Dose

Products Affected

- LENVIMA 14 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 fill
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lenvima 18 MG Daily Dose

Products Affected

- LENVIMA 18 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lenvima 20 MG Daily Dose

Products Affected

- LENVIMA 20 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 fill
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lenvima 24 MG Daily Dose

Products Affected

- LENVIMA 24 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 fill
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lenvima 8 MG Daily Dose

Products Affected

- LENVIMA 8 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	30 day supply Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lescol

Products Affected

- LESCOL ORAL CAPSULE 20 MG

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

Lescol XL

Products Affected

- LESCOLO XL

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

Lessina

Products Affected

- LESSINA

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

Letairis

Products Affected

- LETAIRIS

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

Leukine

Products Affected

- LEUKINE INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Leuprolide Acetate

Products Affected

- *leuprolide acetate injection*

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

Levalbuterol Tartrate HFA

Products Affected

- *levalbuterol tartrate hfa*

ST Criteria	Documented step through one week each of VENTOLIN HFA AND PROAIR
QL Criteria	2 inhalers Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 09, 2016 Quantity Limits: August 25, 2015

LevETIRAcetam ER

Products Affected

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

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

LevETIRAcetam ER

Products Affected

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

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

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride oral tablet*

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

Levonest

Products Affected

- LEVONEST

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

Levonorgest-Eth Estrad 91-Day

Products Affected

- *levonorgest-eth estrad 91-day oral tablet*
0.1-0.02 & 0.01 mg, 0.15-0.03 mg

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

Levonorgestrel

Products Affected

- *levonorgestrel oral tablet 1.5 mg*

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

Levonorgestrel-Ethinyl Estrad

Products Affected

- *levonorgestrel-ethinyl estrad*

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

Levonorgestrel-Ethinyl Estrad

Products Affected

- *levonorgestrel-ethinyl estrad*

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

Levora 0.15/30 (28)

Products Affected

- LEVORA 0.15/30 (28)

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

Lexapro

Products Affected

- LEXAPRO ORAL TABLET 10 MG

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

Lexapro

Products Affected

- LEXAPRO ORAL TABLET 20 MG, 5 MG

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

Lialda

Products Affected

- LIALDA

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

Lidex

Products Affected

- LIDEX

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

Lidocaine

Products Affected

- *lidocaine external ointment*

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

PA Criteria	Criteria Details
Other Criteria	<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</p> <p>*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</p> <p>***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
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, Sensitivity to amide-type local anesthetics or any other component of the product, Planned use on large surface area of the body or for a period of time over 3 hours as this can lead to increased toxicity, the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), Use in situations where the drug may migrate into the middle ear, beyond the tympanic membrane, History of methemoglobinemia, or if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	*Topical lidocaine/prilocaine cream is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Up to an additional 30 grams per 30 days. Higher additional quantities are not approvable.
QL Criteria	30 GM Per 30 Days
Notes/References	

Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	--

Lindane

Products Affected

- *lindane external*

QL Criteria	60 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Linezolid

Products Affected

- *linezolid oral suspension reconstituted*

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

Linezolid

Products Affected

- *linezolid oral tablet*

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

Linzess

Products Affected

- LINZESS

ST Criteria	Trial of 1 month each of Amitza AND Lactulose or Miralax
QL Criteria	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lipitor

Products Affected

- LIPITOR

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

Lipofen

Products Affected

- LIPOFEN

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

Livalo

Products Affected

- LIVALO

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

Lo Loestrin Fe

Products Affected

- LO LOESTRIN FE

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

Loestrin 1.5/30 (21)

Products Affected

- LOESTRIN 1.5/30 (21)

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

Loestrin 1/20 (21)

Products Affected

- LOESTRIN 1/20 (21)

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

Loestrin Fe 1.5/30

Products Affected

- LOESTRIN FE 1.5/30

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

Loestrin Fe 1/20

Products Affected

- LOESTRIN FE 1/20

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

Lofibra

Products Affected

- LOFIBRA

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

Lofibra

Products Affected

- LOFIBRA

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

Lomedia 24 FE

Products Affected

- LOMEDIA 24 FE

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

Lonsurf

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	100 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lonsurf

Products Affected

- LONSURF ORAL TABLET 20-8.19 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	80 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Loryna

Products Affected

- LORYNA

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

Losartan Potassium

Products Affected

- *losartan potassium oral tablet 50 mg, 25 mg*

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

LoSeasonique

Products Affected

- LOSEASONIQUE

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

Lotronex

Products Affected

- LOTRONEX

PA Criteria	Criteria Details
Covered Uses	severe diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Documented trial of 2 alternatives: diphenoxylate/atropine, loperamide
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lovastatin

Products Affected

- *lovastatin*

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

Lovaza

Products Affected

- LOVAZA

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

Lovenox

Products Affected

- LOVENOX

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

Low-Ogestrel

Products Affected

- LOW-OGESTREL

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

Lucentis

Products Affected

- LUCENTIS

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

Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION 0.01 %

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	Documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	A documented step through one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2016
Revision Date	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lumizyme

Products Affected

- LUMIZYME

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

Lunesta

Products Affected

- LUNESTA

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

Lupaneta Pack

Products Affected

- LUPANETA PACK

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

Lupron Depot

Products Affected

- LUPRON DEPOT

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

Lupron Depot-Ped

Products Affected

- LUPRON DEPOT-PED

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

Lutera

Products Affected

- LUTERA

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

Lynparza

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	480 capsules Per 30 prescriptions
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lysteda

Products Affected

- LYSTEDA

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

Lyza

Products Affected

- LYZA

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

Macugen

Products Affected

- MACUGEN

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

Makena

Products Affected

- MAKENA

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

Maprotiline HCl

Products Affected

- *maprotiline hcl oral tablet 25 mg*

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

Maprotiline HCl

Products Affected

- *maprotiline hcl oral tablet 75 mg*

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

Maprotiline HCl

Products Affected

- *maprotiline hcl oral tablet 50 mg*

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

Marinol

Products Affected

- MARINOL

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	2 caps Per 1 day
Notes/References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Marlissa

Products Affected

- *marlissa*

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED
RELEASE 24 HR* 240 MG

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED
RELEASE 24 HR* 300 MG, 420 MG, 180
MG, 360 MG

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

Maxalt

Products Affected

- MAXALT

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

Maxalt-MLT

Products Affected

- MAXALT-MLT

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

MedroxyPROGESTERone Acetate

Products Affected

- *medroxyprogesterone acetate intramuscular*
suspension*

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

Mekinist

Products Affected

- MEKINIST ORAL TABLET 2 MG

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

Mekinist

Products Affected

- MEKINIST ORAL TABLET 0.5 MG

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

Memantine HCl

Products Affected

- *memantine hcl oral tablet 5 (28)-10 (21) mg*

QL Criteria	1.75 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Menostar

Products Affected

- MENOSTAR

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

Mesalamine

Products Affected

- *mesalamine oral*

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

Metadate CD

Products Affected

- METADATE CD

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

Metadate ER

Products Affected

- METADATE ER ORAL TABLET
EXTENDEDRELEASE* 20 MG

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

Methadone HCl

Products Affected

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

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

Methadone HCl

Products Affected

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

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

Methadone HCl

Products Affected

- *methadone hcl oral tablet*

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

Methadose

Products Affected

- METHADOSE ORAL TABLET

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

Methadose

Products Affected

- METHADOSE ORAL TABLET SOLUBLE

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

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	
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

Products Affected

- METHYLIN ORAL SOLUTION 10 MG/5ML

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

Methylin

Products Affected

- METHYLIN ORAL SOLUTION 5 MG/5ML

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

Methylin

Products Affected

- METHYLIN ORAL TABLET CHEWABLE

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

Methylphenidate HCl

Products Affected

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

QL Criteria	60 ML Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet chewable*
- *methylphenidate hcl oral tablet*

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet
extendedrelease* 20 mg*

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

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

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

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la)*

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

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hr* 100 mg, 50 mg*

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

Metoprolol Succinate ER

Products Affected

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

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

Metoprolol Succinate ER

Products Affected

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

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

Mevacor

Products Affected

- MEVACOR ORAL TABLET 40 MG

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

Miacalcin

Products Affected

- MIACALCIN NASAL

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

Micardis

Products Affected

- MICARDIS

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

Micardis HCT

Products Affected

- MICARDIS HCT

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

MiCort-HC

Products Affected

- MICORT-HC

ST Criteria	A documented step through alclometasone cream/oint or Hydrocort
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 09, 2016 Quantity Limits: August 25, 2015

Microgestin 1.5/30

Products Affected

- MICROGESTIN 1.5/30

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

Microgestin 1/20

Products Affected

- MICROGESTIN 1/20

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

Microgestin FE 1.5/30

Products Affected

- MICROGESTIN FE 1.5/30

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

Microgestin FE 1/20

Products Affected

- MICROGESTIN FE 1/20

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

Migranal

Products Affected

- MIGRANAL

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

Mimvey

Products Affected

- MIMVEY

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

Minastrin 24 Fe

Products Affected

- MINASTRIN 24 FE

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

Minivelle

Products Affected

- MINIVELLE

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

Mirapex ER

Products Affected

- MIRAPEX ER

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

Mircera

Products Affected

- MIRCERA INJECTION

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

Mircette

Products Affected

- MIRCETTE

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

Mirena (52 MG)

Products Affected

- MIRENA (52 MG)

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

Mirtazapine

Products Affected

- *mirtazapine oral*

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

Mitigare

Products Affected

- MITIGARE

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

Modafinil

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	2 tabs Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Modicon (28)

Products Affected

- MODICON (28)

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

Monoclalte-P

Products Affected

- MONOCLATE-P INTRAVENOUS* KIT
1000 UNIT, 1500 UNIT, 250 UNIT

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

Mono-Linyah

Products Affected

- MONO-LINYAH

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

MonoNessa

Products Affected

- MONONESSA

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

Mononine

Products Affected

- MONONINE

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

Monovisc

Products Affected

- MONOVISC

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral tablet
extendedrelease**

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

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral capsule extended release 24 hour*

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

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral tablet
extendedrelease**

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

Morphine Sulfate ER Beads

Products Affected

- *morphine sulfate er beads*

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

Movantik

Products Affected

- MOVANTIK

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

MS Contin

Products Affected

- MS CONTIN ORAL TABLET
EXTENDEDRELEASE*

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

MS Contin

Products Affected

- MS CONTIN ORAL TABLET
EXTENDEDRELEASE*

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

Multaq

Products Affected

- MULTAQ

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

Myalept

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	15 vials Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myorisan

Products Affected

- *myorisan oral capsule 20 mg, 40 mg, 10 mg*

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	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.
ST Criteria	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
QL Criteria	2 capsules Per 1 day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myrbetriq

Products Affected

- MYRBETRIQ

ST Criteria	Documented trial of 1 preferred generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
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

Mytesi

Products Affected

- MYTESI

PA Criteria	Criteria Details
Covered Uses	Diarrhea
Exclusion Criteria	
Required Medical Information	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, intolerability 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naglazyme

Products Affected

- NAGLAZYME

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

Namenda

Products Affected

- NAMENDA

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

Namenda Titration Pak

Products Affected

- NAMENDA TITRATION PAK

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

Namenda XR

Products Affected

- NAMENDA XR

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

Namenda XR Titration Pack

Products Affected

- NAMENDA XR TITRATION PACK

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

Namzarin

Products Affected

- NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR

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

Naratriptan HCl

Products Affected

- *naratriptan hcl*

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

Natazia

Products Affected

- NATAZIA

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

Natesto

Products Affected

- NATESTO

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	3 pumps Per 30 Days
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Natpara

Products Affected

- NATPARA

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

Necon 0.5/35 (28)

Products Affected

- NECON 0.5/35 (28)

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

Necon 1/35 (28)

Products Affected

- NECON 1/35 (28)

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

Necon 1/50 (28)

Products Affected

- NECON 1/50 (28)

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

Necon 10/11 (28)

Products Affected

- NECON 10/11 (28)

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

Nesina

Products Affected

- NESINA

ST Criteria	Trial and failure of 1 month each of (a) Januvia, Janumet, or Janumet XR, and (b) Onglyza or Kombiglyze XR
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neulasta

Products Affected

- NEULASTA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupogen

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupro

Products Affected

- NEUPRO

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

Neurontin

Products Affected

- NEURONTIN ORAL TABLET

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

Neurontin

Products Affected

- NEURONTIN ORAL CAPSULE

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

Nevirapine ER

Products Affected

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

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

Nevirapine ER

Products Affected

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

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

NexAVAR

Products Affected

- NEXAVAR

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

NexIUM

Products Affected

- NEXIUM

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

NexIUM

Products Affected

- NEXIUM

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

NexIUM

Products Affected

- NEXIUM

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

Nexplanon

Products Affected

- NEXPLANON

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

Next Choice One Dose

Products Affected

- NEXT CHOICE ONE DOSE

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

Nicotine

Products Affected

- *nicotine*

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

Nicotine Polacrilex

Products Affected

- *nicotine polacrilex mouth/throat gum*

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

Nicotine Polacrilex

Products Affected

- *nicotine polacrilex mouth/throat lozenge*

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

Nicotrol

Products Affected

- NICOTROL

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

Nicotrol NS

Products Affected

- NICOTROL NS

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

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET
EXTENDED RELEASE 24 HR* 30 MG

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

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET
EXTENDED RELEASE 24 HR* 60 MG

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

Ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 28 days
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nisoldipine ER

Products Affected

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

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

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hr* 17 mg, 34 mg, 20 mg, 40 mg, 8.5 mg*

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

Nora-BE

Products Affected

- NORA-BE

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

Norditropin FlexPro

Products Affected

- NORDITROPIN FLEXP
SUBCUTANEOUS* SOLUTION 15
MG/1.5ML, 10 MG/1.5ML, 5 MG/1.5ML

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

Norditropin FlexPro

Products Affected

- NORDITROPIN FLEXPRO
SUBCUTANEOUS* SOLUTION 30 MG/3ML

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

Norethindrone

Products Affected

- *norethindrone oral*

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

Norethindrone-Eth Estradiol

Products Affected

- *norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg*

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

Norethin-Eth Estradiol-Fe

Products Affected

- *norethin-eth estradiol-fe*

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

Norgestimate-Eth Estradiol

Products Affected

- *norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg*

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

Norgestim-Eth Estrad Triphasic

Products Affected

- *norgestim-eth estrad triphasic oral tablet*
0.18/0.215/0.25 mg-35 mcg

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

Norinyl 1+35 (28)

Products Affected

- NORINYL 1+35 (28)

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

Norinyl 1+50 (28)

Products Affected

- NORINYL 1+50 (28)

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

Nor-QD

Products Affected

- NOR-QD

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

Northera

Products Affected

- NORTHERA ORAL CAPSULE 200 MG, 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Northera.html
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

Northera

Products Affected

- NORTHERA ORAL CAPSULE 300 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Northera.html
QL Criteria	6 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nortrel 0.5/35 (28)

Products Affected

- NORTREL 0.5/35 (28)

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

Nortrel 1/35 (21)

Products Affected

- NORTREL 1/35 (21)

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

Nortrel 1/35 (28)

Products Affected

- NORTREL 1/35 (28)

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

Nortrel 7/7/7

Products Affected

- NORTREL 7/7/7

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

Nova Max Glucose Test

Products Affected

- NOVA MAX GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Novoeight

Products Affected

- NOVOEIGHT

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

NovoLIN 70/30

Products Affected

- NOVOLIN 70/30

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

NovoLIN 70/30 ReliOn

Products Affected

- NOVOLIN 70/30 RELION

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

NovoLIN N

Products Affected

- NOVOLIN N

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

NovoLIN N ReliOn

Products Affected

- NOVOLIN N RELION

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

NovoLIN R

Products Affected

- NOVOLIN R

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

NovoLIN R ReliOn

Products Affected

- NOVOLIN R RELION

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

NovoLOG

Products Affected

- NOVOLOG

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

NovoLOG FlexPen

Products Affected

- NOVOLOG FLEXPEN SUBCUTANEOUS*

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

NovoLOG Mix 70/30

Products Affected

- NOVOLOG MIX 70/30

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

NovoLOG Mix 70/30 FlexPen

Products Affected

- NOVOLOG MIX 70/30 FLEXPEN
SUBCUTANEOUS*

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

NovoSeven RT

Products Affected

- NOVOSEVEN RT

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

Noxafil

Products Affected

- NOXAFIL ORAL TABLET DELAYED
RELEASE

QL Criteria	93 tabs Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nplate

Products Affected

- NPLATE

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

Nucala

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/RESP/Interleukin%20Antagonist.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 injection Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucynta

Products Affected

- NUCYNTA

ST Criteria	Documented step through TWO of the following: MORPHINE, OXYCODONE, HYDROMORPHONE
QL Criteria	6 tabs Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucynta ER

Products Affected

- NUCYNTA ER

PA Criteria	Criteria Details
Covered Uses	(1)Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment, (2)Diabetic peripheral neuropathy
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Chronic Pain or Diabetic peripheral neuropathy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	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.
QL Criteria	2 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

Nuedexta

Products Affected

- NUEDEXTA

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

Nuplazid

Products Affected

- NUPLAZID

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

Nutropin AQ NuSpin 10

Products Affected

- NUTROPIN AQ NUSPIN 10

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

Nutropin AQ NuSpin 20

Products Affected

- NUTROPIN AQ NUSPIN 20

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

Nutropin AQ NuSpin 5

Products Affected

- NUTROPIN AQ NUSPIN 5

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

Nutropin AQ Pen

Products Affected

- NUTROPIN AQ PEN

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NuvaRing

Products Affected

- NUVARING

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

Nuvigil

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
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

Nuvigil

Products Affected

- NUVIGIL ORAL TABLET 50 MG

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
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

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

Nuwiq

Products Affected

- NUWIQ

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

Nymalize

Products Affected

- NYMALIZE

QL Criteria	135.2 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ocaliva

Products Affected

- OCALIVA ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/Primary_Biliary_Cholangitis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/Primary_Biliary_Cholangitis.html
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

Products Affected

- OCELLA

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

Octagam

Products Affected

- OCTAGAM

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

Octreotide Acetate

Products Affected

- *octreotide acetate injection solution 1000 mcg/ml, 50 mcg/ml, 200 mcg/ml, 500 mcg/ml, 100 mcg/ml*

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

Odefsey

Products Affected

- ODEFSEY

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

Odomzo

Products Affected

- ODOMZO

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

Ofev

Products Affected

- OFEV

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

Ogestrel

Products Affected

- OGESTREL

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

OLANZapine

Products Affected

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

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

OLANZapine

Products Affected

- *olanzapine oral tablet 2.5 mg*

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

Oleptro

Products Affected

- OLEPTRO ORAL TABLET EXTENDED
RELEASE 24 HR* 300 MG

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

Oleptro

Products Affected

- OLEPTRO ORAL TABLET EXTENDED
RELEASE 24 HR* 150 MG

QL Criteria	45 tabs Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Olysio

Products Affected

- OLYSIO

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

Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

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

Omeprazole-Sodium Bicarbonate

Products Affected

- *omeprazole-sodium bicarbonate oral packet*

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

Omnaris

Products Affected

- OMNARIS

ST Criteria	Documented trial of 2 weeks each of 1 of the following: trial of Flonase OR Nasalide OR Nasacort 24HR OTC AND Nasonex
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Omnitrope

Products Affected

- OMNITROPE

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

Ondansetron

Products Affected

- *ondansetron*

QL Criteria	60 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 8 mg, 4 mg*

QL Criteria	60 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron HCl

Products Affected

- *ondansetron hcl oral solution*

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

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 24 mg*

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

OneTouch Ultra Blue

Products Affected

- ONETOUCH ULTRA BLUE

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

OneTouch Verio

Products Affected

- ONETOUCH VERIO IN VITRO STRIP

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

OneTouch Verio IQ System

Products Affected

- ONETOUCH VERIO IQ SYSTEM

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

Onexton

Products Affected

- ONEXTON

ST Criteria	one month of the preferred generic alternative, benzoyl peroxide/ clindamycin phosphate gel or benzoyl peroxide/ erythromycin gel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onfi

Products Affected

- ONFI ORAL TABLET 10 MG, 20 MG

QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onglyza

Products Affected

- ONGLYZA

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

Onzetra Xsail

Products Affected

- ONZETRA XSAIL

ST Criteria	A documented step through sumatriptan nasal spray
QL Criteria	1 kit Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opana ER

Products Affected

- OPANA ER ORAL

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	2 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

Opsumit

Products Affected

- OPSUMIT

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

Oramorph SR

Products Affected

- ORAMORPH SR ORAL TABLET
EXTENDEDRELEASE* 15 MG

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

Oravig

Products Affected

- ORAVIG

QL Criteria	14 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orencia

Products Affected

- ORENCIA INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
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 ClickJect

Products Affected

- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orenitram

Products Affected

- ORENITRAM

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

Orfadin

Products Affected

- ORFADIN

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

Orkambi

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orsythia

Products Affected

- ORSYTHIA

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

Ortho Micronor

Products Affected

- ORTHO MICRONOR

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

Ortho Tri-Cyclen (28)

Products Affected

- ORTHO TRI-CYCLEN (28)

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

Ortho Tri-Cyclen Lo

Products Affected

- ORTHO TRI-CYCLEN LO

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

Ortho-Cyclen (28)

Products Affected

- ORTHO-CYCLEN (28)

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

Ortho-Novum 1/35 (28)

Products Affected

- ORTHO-NOVUM 1/35 (28)

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

Ortho-Novum 7/7/7 (28)

Products Affected

- ORTHO-NOVUM 7/7/7 (28)

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

OrthoVisc

Products Affected

- ORTHOVISC INTRA-ARTICULAR*

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

Oseni

Products Affected

- OSENI

ST Criteria	A documented step through one month each of Invokana/Invokamet and either Januvia/Janumet or Onglyza/Kombiglyze
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Osphena

Products Affected

- OSPHENA

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

Otezla

Products Affected

- OTEZLA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 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: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otezla.html
QL Criteria	1 pack Per 1 year
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Otrexup

Products Affected

- OTREXUP

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otrexup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ovcon-35 (28)

Products Affected

- OVCON-35 (28)

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

Oxtellar XR

Products Affected

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

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

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET
EXTENDED RELEASE 24 HR* 600 MG

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

Oxybutynin Chloride

Products Affected

- *oxybutynin chloride oral tablet*

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

OxyCODONE HCl ER

Products Affected

- *oxycodone hcl er oral*

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 HCl ER

Products Affected

- *oxycodone hcl er oral*

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	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxycodone-Ibuprofen

Products Affected

- *oxycodone-ibuprofen*

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

OxyCONTIN

Products Affected

- OXYCONTIN ORAL

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

Oxymorphone HCl ER

Products Affected

- *oxymorphone hcl er*

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

Oxytrol For Women

Products Affected

- OXYTROL FOR WOMEN

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

Ozurdex

Products Affected

- OZURDEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: 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*

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

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hr* 1.5 mg, 6 mg, 3 mg*

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

Pamidronate Disodium

Products Affected

- *pamidronate disodium*

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

Pancreaze

Products Affected

- PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-25000 UNIT, 21000-37000 UNIT, 16800-40000 UNIT, 4200-10000 UNIT

ST Criteria	Documented step through CREON AND ZENPEP
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paragard Intrauterine Copper

Products Affected

- PARAGARD INTRAUTERINE COPPER

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

Paricalcitol

Products Affected

- *paricalcitol oral*

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

PARoxetine HCl

Products Affected

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

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

PARoxetine HCl

Products Affected

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

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er*

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

Paxil

Products Affected

- PAXIL ORAL TABLET 10 MG, 20 MG

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

Paxil

Products Affected

- PAXIL ORAL SUSPENSION

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

Paxil

Products Affected

- PAXIL ORAL TABLET 30 MG, 40 MG

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

Paxil CR

Products Affected

- PAXIL CR

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

PEG 3350/Electrolytes

Products Affected

- *peg 3350/electrolytes*

QL Criteria	1 bottle Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PEG-3350/Electrolytes

Products Affected

- *peg-3350/electrolytes*

QL Criteria	1 bottle Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pegasy

Products Affected

- PEGASYS SUBCUTANEOUS* SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

Pegasys ProClick

Products Affected

- PEGASYS PROCLICK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

PegIntron

Products Affected

- PEGINTRON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

Peg-Intron

Products Affected

- PEG-INTRON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

Peg-Intron Redipen

Products Affected

- PEG-INTRON REDIPEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

Peg-Intron Redipen Pak 4

Products Affected

- PEG-INTRON REDIPEN PAK 4
SUBCUTANEOUS* KIT 120 MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical 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

Pennsaid

Products Affected

- PENNSAID TRANSDERMAL SOLUTION 2
%

ST Criteria	Documented Trial of 1 month of Voltaren Gel
QL Criteria	112 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 500 MG

QL Criteria	8 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 250 MG

QL Criteria	16 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Perforomist

Products Affected

- PERFOROMIST

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trail of one month each of FORADIL AND SEREVENT
QL Criteria	60 vials Per 1 fill
Notes/References	Annual Review: 07/2016
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pertzye

Products Affected

- PERTZYE

ST Criteria	Documented step through CREON AND ZENPEP
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Phenoxybenzamine HCl

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/antihypertensive_misc.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Philith

Products Affected

- PHILITH

QL Criteria	1.5 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Picato

Products Affected

- PICATO

QL Criteria	1 box Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pioglitazone HCl

Products Affected

- *pioglitazone hcl*

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pioglitazone HCl-Glimepiride

Products Affected

- *pioglitazone hcl-glimepiride*

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-metformin hcl*

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pirmella 1/35

Products Affected

- PIRMELLA 1/35

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plan B One-Step

Products Affected

- PLAN B ONE-STEP

QL Criteria	1 Pack Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plavix

Products Affected

- PLAVIX

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plavix

Products Affected

- PLAVIX

QL Criteria	1 tab Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy

Products Affected

- PLEGRIDY SUBCUTANEOUS* 125 MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy

Products Affected

- PLEGRIDY SUBCUTANEOUS* 125 MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	2 syringes Per 28 months
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK
SUBCUTANEOUS* 63 & 94 MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK
SUBCUTANEOUS* 63 & 94 MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	1 kit Per 365 months
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pomalyst

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Portia-28

Products Affected

- PORTIA-28

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Potiga

Products Affected

- POTIGA ORAL TABLET 200 MG

QL Criteria	3 tabs Per 1 Day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Potiga

Products Affected

- POTIGA ORAL TABLET 400 MG, 300 MG

QL Criteria	3 tabs Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Potiga

Products Affected

- POTIGA ORAL TABLET 50 MG

QL Criteria	6 tabs Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pradaxa

Products Affected

- PRADAXA

ST Criteria	Documented step through ELIQUIS and XARELTO
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Praluent

Products Affected

- PRALUENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
QL Criteria	2 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pravachol

Products Affected

- PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG

QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Precision Xtra Blood Glucose

Products Affected

- PRECISION XTRA BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prefest

Products Affected

- PREFEST

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prenate Mini

Products Affected

- PRENATE MINI

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prevacid

Products Affected

- PREVACID ORAL CAPSULE DELAYED RELEASE 15 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	
QL Criteria	1 tab Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 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	
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prevacid 24HR

Products Affected

- PREVACID 24HR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A. Documentation of trial and failure of Nexium AND ONE of the following: Prilosec OTC/ Prilosec*, Prevacid 24H OTC, Zegerid OTC, or Protonix*
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prevacid SoluTab

Products Affected

- PREVACID SOLUTAB

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented step through 2 generic PPI or OTC (i.e. omeprazole, pantoprazole, esomeprazole, lansoprazole, Prevacid 24H, Nexium)
QL Criteria	1 tab 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

Previfem

Products Affected

- PREVIFEM

QL Criteria	1.5 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prezista

Products Affected

- PREZISTA ORAL SUSPENSION

QL Criteria	12 milliliters Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prezista

Products Affected

- PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prezista

Products Affected

- PREZISTA ORAL TABLET 800 MG

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PriLOSEC

Products Affected

- PRILOSEC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A. Documentation of trial and failure of Nexium AND ONE of the following: Prilosec OTC/ Prilosec*, Prevacid 24H OTC, Zegerid OTC, or Protonix*
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PriLOSEC

Products Affected

- PRILOSEC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A. Documentation of trial and failure of Nexium AND ONE of the following: Prilosec OTC/ Prilosec*, Prevacid 24H OTC, Zegerid OTC, or Protonix*
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pristiq

Products Affected

- PRISTIQ

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pristiq

Products Affected

- PRISTIQ

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Privigen

Products Affected

- PRIVIGEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ProAir RespiClick

Products Affected

- PROAIR RESPICLICK

QL Criteria	2 inhalers Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Procardia XL

Products Affected

- PROCARDIA XL ORAL TABLET
EXTENDED RELEASE 24 HR* 30 MG, 90
MG

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Procardia XL

Products Affected

- PROCARDIA XL ORAL TABLET
EXTENDED RELEASE 24 HR* 60 MG

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ProCentra

Products Affected

- PROCENTRA

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of 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	40 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Procrit

Products Affected

- PROCIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: 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: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
QL Criteria	240 caps Per 30 monthss
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 75 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
QL Criteria	750 caps Per 30 monthss
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Profilnine

Products Affected

- PROFILNINE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Profilnine SD

Products Affected

- PROFILNINE SD

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prolastin-C

Products Affected

- PROLASTIN-C INTRAVENOUS*
SOLUTION RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Covered Uses	pending
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	pending
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prolia

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tab Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prometrium

Products Affected

- PROMETRIUM

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Propafenone HCl ER

Products Affected

- *propafenone hcl er*

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Protopic

Products Affected

- PROTOPIC

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis, Vitiligo
Exclusion Criteria	
Required Medical Information	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition OR member is being treated for atopic dermatitis (eczema) in an area at high risk for skin atrophy such as face, eyelids, or genital areas
Notes/References	

Revision Date	Prior Authorization: October 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	--

Proventil HFA

Products Affected

- PROVENTIL HFA

ST Criteria	Documented step through one week each of VENTOLIN HFA AND PROAIR
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 09, 2016 Quantity Limits: August 25, 2015

Provigil

Products Affected

- PROVIGIL

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	2 tabs Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PROzac

Products Affected

- PROZAC ORAL CAPSULE 40 MG

QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PROzac

Products Affected

- PROZAC ORAL CAPSULE 10 MG

QL Criteria	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PROzac

Products Affected

- PROZAC ORAL CAPSULE 20 MG

QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PROzac Weekly

Products Affected

- PROZAC WEEKLY

QL Criteria	4 caps Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pulmicort

Products Affected

- PULMICORT

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	For ages 5-8 documented inability to use metered dose inhalers
Age Restrictions	Less than 8 years of age
Prescriber Restrictions	
Coverage Duration	Up to the age of 8
Other Criteria	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
Notes/References	Annual Review: 07/2016
Revision Date	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

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ampules Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Purixan

Products Affected

- PURIXAN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
QL Criteria	1 bottle Per 1 month
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qbrelis

Products Affected

- QBRELIS

PA Criteria	Criteria Details
Covered Uses	Hypertension, Heart Failure, Myocardial Infarction
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension (Approved only for ages 6 and older), Heart failure, or Myocardial Infarction AND must have a documented inability to swallow tablets/capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl

Products Affected

- QNASL

ST Criteria	adequate trial of 2 weeks each of 1 of the following: trial of Flonase OR Nasalide OR Nasacort 24HR OTC AND Nasonex
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl Childrens

Products Affected

- QNASL CHILDRENS

ST Criteria	adequate trial of 2 weeks each of 1 of the following: trial of Flonase OR Nasalide OR Nasacort 24HR OTC AND Nasonex
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qualaquin

Products Affected

- QALAQVIN

QL Criteria	42 caps Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Quartette

Products Affected

- QUARTETTE

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Quasense

Products Affected

- QUASENSE

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qudexy XR

Products Affected

- QUDEXY XR ORAL 150 MG, 200 MG

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qudexy XR

Products Affected

- QUDEXY XR ORAL 25 MG, 100 MG, 50 MG

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 100 mg, 50 mg*

QL Criteria	3 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

QL Criteria	6 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 400 mg, 300 mg*

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

QL Criteria	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Quillivant XR

Products Affected

- QUILLIVANT XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit disorder, Attention deficit hyperactivity disorder
Exclusion Criteria	
Required Medical Information	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.
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	1 bottle Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QuiNINE Sulfate

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Covered Uses	Malaria, Symptomatic babesiosis, Asymptomatic babesiosis
Exclusion Criteria	
Required Medical Information	FOR SYMPTOMATIC BABESIOSIS: Serum contains antibody to babesia, blood contains identifiable babesial parasite on smear or babesial DNA by PCR, and documentation that Qalapaquin will be used in combination with clindamycin (IV preferred for severe babesiosis). FOR ASYMPTOMATIC BABESIOSIS: Positive babesial smears and/or PCR, parasitemia persists for longer than 3 months, and documentation that Qalapaquin will be used in combination with clindamycin (IV preferred for severe babesiosis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Malaria: 7 days (42 capsules). Babesiosis: 10 days (60 capsules).
Other Criteria	
QL Criteria	42 capsules Per 1 fill
Notes/References	
Revision Date	Prior Authorization: October 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RA TRUEtest Test

Products Affected

- RA TRUETEST TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 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

Products Affected

- RANEXA

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rasuvo

Products Affected

- RASUVO

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Otrexup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 bottles Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rayos

Products Affected

- RAYOS

ST Criteria	Documented step through PREDNISONE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Razadyne

Products Affected

- RAZADYNE 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

Rebif

Products Affected

- REBIF SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical 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

Rebif Rebidose

Products Affected

- REBIF REBIDOSE SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical 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

Rebif Rebidoose Titration Pack

Products Affected

- REBIF REBIDOSE TITRATION PACK
SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical 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

Rebif Titration Pack

Products Affected

- REBIF TITRATION PACK
SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical 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

Reclast

Products Affected

- RECLAST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reclipsen

Products Affected

- RECLIPSEN

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Recombinate

Products Affected

- RECOMBINATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rectiv

Products Affected

- RECTIV

QL Criteria	30 grams Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relenza Diskhaler

Products Affected

- RELENZA DISKHALER

QL Criteria	20 inhalations Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS* SOLUTION
8 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.4 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain and documented concomitant use of opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS* SOLUTION
12 MG/0.6ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.6 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relpax

Products Affected

- RELPAX

QL Criteria	6 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remeron

Products Affected

- REMERON

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remeron SolTab

Products Affected

- REMERON SOLTAB

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remicade

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical 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

Remodulin

Products Affected

- REMODULIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repaglinide-Metformin HCl

Products Affected

- *repaglinide-metformin hcl*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repatha

Products Affected

- REPATHA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
QL Criteria	2 injections Per 28 Days
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: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
QL Criteria	1 syringe Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repatha SureClick

Products Affected

- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
QL Criteria	2 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Requip XL

Products Affected

- REQUIP XL ORAL TABLET EXTENDED
RELEASE 24 HR* 2 MG, 4 MG, 6 MG, 8 MG

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Requip XL

Products Affected

- REQUIP XL ORAL TABLET EXTENDED
RELEASE 24 HR* 12 MG

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rescula

Products Affected

- RESCULA

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	Documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	A documented step through one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2016
Revision Date	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Restoril

Products Affected

- RESTORIL ORAL CAPSULE 22.5 MG, 7.5 MG

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Retin-A

Products Affected

- RETIN-A

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Retin-A Micro

Products Affected

- RETIN-A MICRO

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Retin-A Micro Pump

Products Affected

- RETIN-A MICRO PUMP

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Revatio

Products Affected

- REVATIO INTRAVENOUS*
- REVATIO ORAL SUSPENSION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Revatio

Products Affected

- REVATIO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
QL Criteria	3 tabs Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Revlimid

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 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

Products Affected

- REYATAZ ORAL CAPSULE 150 MG, 300 MG

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 200 MG

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RiaSTAP

Products Affected

- RIASTAP

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rilutek

Products Affected

- RILUTEK

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Riluzole

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 35 mg*
- *risedronate sodium oral tablet delayed release*

QL Criteria	4 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 5 mg, 30 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

ST Criteria	Documented trial and failure of 1 month of generic alendronate weekly (70mg weekly dose)
QL Criteria	1 tablet Per 28 Days
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 1 MG, 2 MG, 0.25 MG, 0.5 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- RISPERDAL ORAL SOLUTION

ST Criteria	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 4 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 3 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	3 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET
DISPERSIBLE 2 MG, 1 MG, 0.5 MG

ST Criteria	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET
DISPERSIBLE 3 MG

ST Criteria	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET
DISPERSIBLE 4 MG

ST Criteria	A documented step through aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral tablet 4 mg*
- *risperidone oral tablet dispersible 4 mg*

QL Criteria	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral tablet dispersible 1 mg, 2 mg, 0.5 mg*
- *risperidone oral tablet 2 mg, 0.25 mg, 0.5 mg, 1 mg*

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral tablet 3 mg*
- *risperidone oral tablet dispersible 3 mg*

QL Criteria	3 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 1 MG, 2 MG, 0.5 MG

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 3 MG

QL Criteria	3 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 4 MG

QL Criteria	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin

Products Affected

- RITALIN

PA Criteria	Criteria Details
Covered Uses	Attention deficit disorder, Attention deficit hyperactivity disorder
Exclusion Criteria	
Required Medical Information	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.
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	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 40 MG, 10 MG, 20 MG

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 30 MG

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 60 MG

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rivastigmine

Products Affected

- *rivastigmine*

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

Rivastigmine Tartrate

Products Affected

- *rivastigmine tartrate*

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

Rixubis

Products Affected

- RIXUBIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release*
24 hr* 12 mg

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release*
24 hr* 2 mg, 4 mg, 6 mg, 8 mg

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

QL Criteria	1 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rozerem

Products Affected

- ROZEREM

ST Criteria	A. Documentation of a trial and failure with Ambien IR (zolpidem tartrate) or Sonata (zalelpon) ANDB. Documentation of a trial and failure with Ambien CR (zolpidem tartrate extended-release) or Lunesta
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ruconest

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angi_oedema.html
Exclusion Criteria	
Required Medical 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

Rythmol SR

Products Affected

- RYTHMOL SR

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Safyral

Products Affected

- SAFYRAL

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saizen

Products Affected

- SAIZEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Samsca

Products Affected

- SAMSCA ORAL TABLET 15 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Samsca

Products Affected

- SAMSCA ORAL TABLET 30 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sancuso

Products Affected

- SANCUSO

QL Criteria	1 patch Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SandoSTATIN

Products Affected

- SANDOSTATIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SandoSTATIN LAR Depot

Products Affected

- SANDOSTATIN LAR DEPOT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saphris

Products Affected

- SAPHRIS

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
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

Savaysa

Products Affected

- SAVAYSA

ST Criteria	Documented Trial of Eliquis AND Xarelto
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella

Products Affected

- SAVELLA

QL Criteria	2 tabs Per 1 day
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella Titration Pack

Products Affected

- SAVELLA TITRATION PACK

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saxenda

Products Affected

- SAXENDA

PA Criteria	Criteria Details
Covered Uses	Weightloss
Exclusion Criteria	Members without weightloss benefit. Members not in a state where coverage is mandated.
Required Medical Information	Member must have a body mass index greater than 30 kilograms per meter squared or a body mass index greater than 27 kilograms per meter squared with one or more of the following obesity related risk factors considered serious enough to warrant pharmacotherapy: Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion), Dyslipidemia (LDL cholesterol greater than 160 mg/dL, HDL cholesterol less than 35 mg/dL, or Triglycerides greater than 400 mg/dL), Coronary Heart Disease, Type 2 Diabetes Mellitus, or Obstructive Sleep Apnea (OSA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Coverage 16 weeks
Other Criteria	For reauthorization after initial 16 week coverage: Member has experienced a documented weight loss of at least 4%.
ST Criteria	A documented trial of TWO of the following preferred oral alternatives: Belviq (lorcaserin), Qsymia (phentermine/topiramate), phentermine, phendimetrazine, diethylpropion, benzphetamine)
Notes/References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Seasonique

Products Affected

- SEASONIQUE

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Seebri Neohaler

Products Affected

- SEEBRI NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of Spiriva and Incruse Ellipta
QL Criteria	2 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Selzentry

Products Affected

- SELZENTRY ORAL TABLET 150 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sensipar

Products Affected

- SENSIPAR

PA Criteria	Criteria Details
Covered Uses	Documented diagnosis of hyperparathyroidism & parathyroid carcinoma or other FDA approved indication
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Serevent Diskus

Products Affected

- SEREVENT DISKUS

QL Criteria	1 box Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 300 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
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

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 50 MG, 100 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	3 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 400 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 25 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	6 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 200 MG

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	4 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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 tab 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

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 tabs 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* 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	6 tabs Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Serostim

Products Affected

- SEROSTIM SUBCUTANEOUS* SOLUTION
RECONSTITUTED 6 MG, 5 MG, 4 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral concentrate*

QL Criteria	10 ML Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

QL Criteria	1.5 tag Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 amps Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Signifor LAR

Products Affected

- SIGNIFOR LAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 injections Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sildenafil Citrate

Products Affected

- *sildenafil citrate oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simcor

Products Affected

- SIMCOR

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simponi

Products Affected

- SIMPONI SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi.html
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

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi_Aria.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
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

Products Affected

- *simvastatin oral*

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Singular

Products Affected

- SINGULAIR

QL Criteria	1 pack Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Singular

Products Affected

- SINGULAIR

QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sirturo

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antimycobacterial_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	188 tabs Per 365 dayss
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sivextro

Products Affected

- SIVEXTRO ORAL

QL Criteria	6 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Skyla

Products Affected

- SKYLA

QL Criteria	1 unit Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Soliris

Products Affected

- SOLIRIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/soliris.html
Exclusion Criteria	
Required Medical Information	
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

Somatuline Depot

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sonata

Products Affected

- SONATA

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Soolantra

Products Affected

- SOOLANTRA

ST Criteria	A documented trial of one month each of any of the preferred topical generic alternatives, metronidazole OR sulfacetamide sodium with sulfu
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Soriatane

Products Affected

- SORIATANE ORAL CAPSULE 10 MG

QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Soriatane

Products Affected

- SORIATANE ORAL CAPSULE 25 MG, 17.5 MG

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sovaldi

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Spiriva HandiHaler

Products Affected

- SPIRIVA HANDIHALER

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT

QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sporanox

Products Affected

- SPORANOX ORAL CAPSULE

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sporanox Pulsepak

Products Affected

- SPORANOX PULSEPAK

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sprintec 28

Products Affected

- SPRINTEC 28

QL Criteria	1.5 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Spritam

Products Affected

- SPRITAM

ST Criteria	Documented trial and failure of immediate release levetiracetam tablets
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

Sprix

Products Affected

- SPRIX

QL Criteria	5 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 70 MG, 80 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
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: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
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

Products Affected

- SRONYX

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stelara

Products Affected

- STELARA INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2016/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 vials Per 30 Days
Notes/References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stelara

Products Affected

- STELARA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stiolto Respimat

Products Affected

- STIOLTO RESPIMAT

QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 25 MG, 40 MG, 60 MG, 10 MG, 18 MG

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 100 MG, 80 MG

QL Criteria	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strensiq

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Striant

Products Affected

- STRIANT

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	2 buccals Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

Stribild

Products Affected

- STRIBILD

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of human immunodeficiency virus (HIV), and a documented viral load assay AND CD4 count indicating that the patient is stable on Stribild (stable or increase in CD4 counts AND viral load less than 50 copies/ml) (FOR renewals/continuations ONLY). For treatment naïve patients only, 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 A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of one of the preferred regimens: 1) Triumeq (dolutegravir/abacavir/lamivudine) OR 2) Tivicay (dolutegravir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine) OR 3) Isentress (Raltegravir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine) OR 4) Prezista (Darunavir) plus Norvir (ritonavir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: October 27, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Striverdi Respimat

Products Affected

- STRIVERDI RESPIMAT

QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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	2 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

Subsys

Products Affected

- SUBSYS

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A documented diagnosis of cancer with concomitant use of around the clock long acting opioid therapy for cancer pain, requiring management of breakthrough pain and meet step therapy requirements, or the patient is terminally ill.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))
ST Criteria	Documented trial or intolerance to two (2) immediate-release opioids (morphine, hydrocodone, oxycodone, or hydromorphone) AND fentanyl citrate lozenge
QL Criteria	8 sprays Per 1 day

Notes/ References	
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sular

Products Affected

- SULAR ORAL TABLET EXTENDED
RELEASE 24 HR* 8.5 MG, 17 MG, 34 MG

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SulfaSALazine

Products Affected

- *sulfasalazine oral*

QL Criteria	8 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sulfazine

Products Affected

- SULFAZINE

QL Criteria	8 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan

Products Affected

- *sumatriptan nasal*

QL Criteria	6 sprays Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous* solution*
6 mg/0.5ml

QL Criteria	8 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate oral*

QL Criteria	9 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous** 4 mg/0.5ml, 6 mg/0.5ml

QL Criteria	2 boxes Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill subcutaneous**

QL Criteria	2 boxes Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Supartz

Products Affected

- SUPARTZ INTRA-ARTICULAR*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html
Notes/References	
Revision Date	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Supprelin LA

Products Affected

- SUPPRELIN LA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/miscendocrine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Syeda

Products Affected

- SYEDA

QL Criteria	1.5 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sylatron

Products Affected

- SYLATRON SUBCUTANEOUS* KIT 200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Symbicort

Products Affected

- SYMBICORT

QL Criteria	1 inhaler Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Symbyax

Products Affected

- SYMBYAX

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SymlinPen 120

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	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
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months (initial)
Other Criteria	12 month extended approval if patient has demonstrated expected reduction in HbA1c since starting therapy.
Notes/References	Annual Review: 05/2016
Revision Date	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
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	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
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months (initial)
Other Criteria	12 month extended approval if patient has demonstrated expected reduction in HbA1c since starting therapy.
Notes/References	Annual Review: 05/2016
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synagis

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Synagis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synarel

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/miscendocrine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synjardy

Products Affected

- SYNJARDY

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synvisc

Products Affected

- SYNVISC INTRA-ARTICULAR*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html
Notes/References	
Revision Date	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synvisc One

Products Affected

- SYNVISIC ONE INTRA-ARTICULAR*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/viscosupplements.html
Notes/References	
Revision Date	Prior Authorization: June 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Syprine

Products Affected

- SYPRINE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Notes/References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taclonex

Products Affected

- TACLONEX EXTERNAL OINTMENT

ST Criteria	Documented trial and failure of 1 medium to high potency steroid indicated for patients condition.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tacrolimus

Products Affected

- *tacrolimus external*

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis, Vitiligo
Exclusion Criteria	
Required Medical Information	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition OR member is being treated for atopic dermatitis (eczema) in an area at high risk for skin atrophy such as face, eyelids, or genital areas
Notes/References	

Revision Date	Prior Authorization: October 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	--

Tafinlar

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 caps Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tagrisso

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Take Action

Products Affected

- TAKE ACTION

QL Criteria	1 tab Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taltz

Products Affected

- TALTZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Taltz.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Taltz.html
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tamiflu

Products Affected

- TAMIFLU ORAL CAPSULE

QL Criteria	20 caps Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tamiflu

Products Affected

- TAMIFLU ORAL SUSPENSION
RECONSTITUTED 6 MG/ML

QL Criteria	3 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tanzeum

Products Affected

- TANZEUM

ST Criteria	Trial and failure of 1 month each of Victoza and Trulicity
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tarceva

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tasigna

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
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

Products Affected

- TAYTULLA

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tazorac

Products Affected

- TAZORAC

ST Criteria	Documented step through RETIN-A*
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 240 MG

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 300 MG, 360 MG, 120
MG, 180 MG

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tecfidera

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	2 caps Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Technivie

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
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

Tekturna

Products Affected

- TEKTURNA

ST Criteria	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)
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

Tekturna HCT

Products Affected

- TEKTURNA HCT

ST Criteria	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)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Telmisartan

Products Affected

- *telmisartan*

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Telmisartan-Amlodipine

Products Affected

- *telmisartan-amlodipine*

ST Criteria	Documented step through AMLODIPINE in combination with TWO of the following (brand or generic if available): ATACAND, AVAPRO, COZAAR, MICARDIS
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Telmisartan-HCTZ

Products Affected

- *telmisartan-hctz*

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Temazepam

Products Affected

- *temazepam oral capsule 22.5 mg, 7.5 mg*

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Temodar

Products Affected

- TEMODAR ORAL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Temozolomide

Products Affected

- *temozolomide*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testim

Products Affected

- TESTIM

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	2 10 gm packets Per 1 day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

Testosterone

Products Affected

- *testosterone transdermal gel 25 mg/2.5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2.5 grams Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal gel 10 mg/act (2%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 pumps Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal gel 50 mg/5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	10 grams Per 1 fill
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal gel 12.5 mg/act (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	10 grams Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tetrabenazine

Products Affected

- tetrabenazine oral tablet 25 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thalomid

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thiola

Products Affected

- THIOLA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TiaGABine HCl

Products Affected

- *tia gabine hcl oral tablet 2 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TiaGABine HCl

Products Affected

- *tia gabine hcl oral tablet 4 mg*

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tiazac

Products Affected

- TIAZAC ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 420 MG, 360 MG, 120
MG, 300 MG, 180 MG

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tiazac

Products Affected

- TIAZAC ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 240 MG

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tilia Fe

Products Affected

- TILIA FE

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tivicay

Products Affected

- TIVICAY

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tivicay

Products Affected

- TIVICAY

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

Tivorbex

Products Affected

- TIVORBEX

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tobi

Products Affected

- TOBI

QL Criteria	56 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tobi Podhaler

Products Affected

- TOBI PODHALER

QL Criteria	1 box Per 28 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tobramycin

Products Affected

- *tobramycin inhalation*

QL Criteria	10 ml Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Topamax Sprinkle

Products Affected

- TOPAMAX SPRINKLE

QL Criteria	4 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Topiramate

Products Affected

- *topiramate oral capsule sprinkle*

QL Criteria	4 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toprol XL

Products Affected

- TOPROL XL ORAL TABLET EXTENDED
RELEASE 24 HR* 100 MG, 50 MG

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toprol XL

Products Affected

- TOPROL XL ORAL TABLET EXTENDED
RELEASE 24 HR* 200 MG

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toprol XL

Products Affected

- TOPROL XL ORAL TABLET EXTENDED
RELEASE 24 HR* 25 MG

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toujeo SoloStar

Products Affected

- TOUJEO SOLOSTAR

PA Criteria	Criteria Details
Covered Uses	Type 1 or Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Type 1 or Type 2 Diabetes Mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Documented one month trial of LEVEMIR
Notes/References	Annual Review: 03/2016
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Toviaz

Products Affected

- TOVIAZ

ST Criteria	Documented trial of 2 preferred alternatives: Vesicare OR Myrbetriq AND one generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
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

Tracleer

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tradjenta

Products Affected

- TRADJENTA

ST Criteria	Trial and failure of 1 month each of (a) Januvia, Janumet, or Janumet XR, and (b) Onglyza or Kombiglyze XR
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral capsule extended release*
24 hour 300 mg, 100 mg, 200 mg

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tramadol-Acetaminophen

Products Affected

- *tramadol-acetaminophen*

QL Criteria	8 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

QL Criteria	30 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Travoprost

Products Affected

- *travoprost*

ST Criteria	A documented step through one week of latanoprost and one week of Travatan Z
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trelstar

Products Affected

- TRELSTAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trelstar Mixject

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin

Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Tretinoin Microsphere

Products Affected

- *tretinoin microsphere*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Tretinoin Microsphere Pump

Products Affected

- *tretinoin microsphere pump*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Tretin-X

Products Affected

- TRETIN-X EXTERNAL CREAM 0.0375 %

QL Criteria	50 grams Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretin-X

Products Affected

- TRETIN-X EXTERNAL CREAM 0.075 %

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: 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)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
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

Tretten

Products Affected

- TRETEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Treximet

Products Affected

- TREXIMET

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tribenzor

Products Affected

- TRIBENZOR

ST Criteria	Documented step through AMLODIPINE in combination with TWO of the following: ATACAND HCT, AVALIDE, HYZAAR, MICARDIS HCT
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tricor

Products Affected

- TRICOR

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Estarylla

Products Affected

- TRI-ESTARYLLA

QL Criteria	1.5 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triglide

Products Affected

- TRIGLIDE ORAL TABLET 160 MG

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Legest Fe

Products Affected

- TRI-LEGEST FE

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Linyah

Products Affected

- TRI-LINYAH

QL Criteria	1.5 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trilipix

Products Affected

- TRILIPIX

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TriNessa (28)

Products Affected

- TRINESSA (28)

QL Criteria	1.5 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Norinyl (28)

Products Affected

- TRI-NORINYL (28)

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trintellix

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
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	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) (NSO)
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

Tri-Previfem

Products Affected

- TRI-PREVIFEM

QL Criteria	1.5 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Sprintec

Products Affected

- TRI-SPRINTEC

QL Criteria	1.5 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triumeq

Products Affected

- TRIUMEQ

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trivora (28)

Products Affected

- TRIVORA (28)

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trokendi XR

Products Affected

- TROKENDI XR ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 200 MG

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trokendi XR

Products Affected

- TROKENDI XR ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 100 MG,
25 MG, 50 MG

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trospium Chloride

Products Affected

- *trospium chloride*

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trospium Chloride ER

Products Affected

- *trospium chloride er*

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TRUEtest Test

Products Affected

- TRUETEST TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TrueTrack Test

Products Affected

- TRUETRACK TEST

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	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%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
ST Criteria	Documented step through one month of ONE TOUCH TEST STRIPS
QL Criteria	300 strips Per 30 days
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trulicity

Products Affected

- TRULICITY

QL Criteria	4 injections Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Truvada

Products Affected

- TRUVADA

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of human immunodeficiency virus (HIV) in a patient who weighs 17KG or more OR initiating therapy for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk who have documentation of all of the following: A negative HIV antibody test taken immediately before starting Truvada for PrEP and every 3 months thereafter while on therapy, confirmation that creatinine clearance value is greater than or equal to 60 mL/min before initiating Truvada for PrEP, and serum creatinine and calculate creatinine clearance checks performed at 3 months after initiation and then every 6 months thereafter. NOTE: Members may receive a 30 days' supply of medication upon initial request of Truvada for PrEP diagnosis. After 30 days, above criteria must be met.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	none
Prescriber Restrictions	
Coverage Duration	36 months HIV, 1 month initial PREP, 3 month PREP renewal
Other Criteria	4. Gilead Sciences, Inc. Truvada® (emtricitabine/tenofovir disoproxil fumarate) tablets, for oral use Foster City, CA: Gilead Sciences; 2004. Available at http://gilead.com/~media/files/pdfs/medicines/hiv/truvada/truvada_pi.pdf Accessed June 9th, 2016.
Notes/References	
Revision Date	Prior Authorization: July 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tudorza Pressair

Products Affected

- TUDORZA PRESSAIR INHALATION
AEROSOL POWDER, BREATH
ACTIVATED 400 MCG/ACT

ST Criteria	Trial of 1 month each of Spiriva and Incruse Ellipta
QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TussiCaps

Products Affected

- TUSSICAPS

QL Criteria	20 caps Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Twynsta

Products Affected

- TWYNSTA

ST Criteria	Documented step through AMLODIPINE in combination with TWO of the following (brand or generic if available): ATACAND, AVAPRO, COZAAR, MICARDIS
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tybost

Products Affected

- TYBOST

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tykerb

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tysabri

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical 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

Tyvaso

Products Affected

- TYVASO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
QL Criteria	1 amp Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyvaso Refill

Products Affected

- TYVASO REFILL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
QL Criteria	1 amp Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyvaso Starter

Products Affected

- TYVASO STARTER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
QL Criteria	1 amp Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyzeka

Products Affected

- TYZEKA

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

Uceris

Products Affected

- UCERIS

PA Criteria	Criteria Details
Covered Uses	Active mild to moderate ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of ACTIVE mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge, requiring induction of remission.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 canisters Per 42 months
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uceris

Products Affected

- UCERIS ORAL

ST Criteria	A documented trial of Asacol HD, Delzicol, Lialda or Pentasa
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ulesfia

Products Affected

- ULESFIA

QL Criteria	3 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uloric

Products Affected

- ULORIC

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultracet

Products Affected

- ULTRACET

QL Criteria	8 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uptravi

Products Affected

- UPTRAVI ORAL
- UPTRAVI ORAL TABLET 200 MCG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uptravi

Products Affected

- UPTRAVI ORAL TABLET 1600 MCG, 600 MCG, 1000 MCG, 1200 MCG, 400 MCG, 1400 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uroxatral

Products Affected

- UROXATRAL

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valchlor

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tube Per 1 month
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valcyte

Products Affected

- VALCYTE ORAL SOLUTION
RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valcyte

Products Affected

- VALCYTE ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	102 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl oral solution reconstituted*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	102 tablets Per 30 30s
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valsartan

Products Affected

- *valsartan*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valsartan-Hydrochlorothiazide

Products Affected

- *valsartan-hydrochlorothiazide*

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vanos

Products Affected

- VANOS

ST Criteria	Documented step through TWO VERY HIGH POTENCY TOPICAL STEROIDS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vantas

Products Affected

- VANTAS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Varubi

Products Affected

- VARUBI

QL Criteria	4 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vascepa

Products Affected

- VASCEPA ORAL CAPSULE 1 GM

QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vecamyl

Products Affected

- VECAMYL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/antihypertensive_misc.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CV/antihypertensive_misc.html
QL Criteria	2 tabs Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Veletri

Products Affected

- VELETRI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Velivet

Products Affected

- VELIVET

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Veltassa

Products Affected

- VELTASSA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Veltassa.html
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

Products Affected

- VELTIN

ST Criteria	Documented step through RETIN-A*
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 50 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 10 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	40 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venclexta Starting Pack

Products Affected

- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 pack Per 28 days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

QL Criteria	4 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

QL Criteria	3 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

QL Criteria	6 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

QL Criteria	5 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release*
24 hr 150 mg*

QL Criteria	2 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release*
24 hr* 75 mg, 225 mg, 37.5 mg

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

QL Criteria	2 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg*

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ventavis

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Veramyst

Products Affected

- VERAMYST

ST Criteria	adequate trial of 2 weeks each of 1 of the following: trial of Flonase OR Nasalide OR Nasacort 24HR OTC AND Nasonex
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release*
24 hour 200 mg

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release*
24 hour 100 mg, 300 mg

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verelan PM

Products Affected

- VERELAN PM ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 300 MG,
100 MG

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verelan PM

Products Affected

- VERELAN PM ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 200 MG

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Versacloz

Products Affected

- VERSACLOZ

ST Criteria	Documented step through Clozaril tablets
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

VESIcare

Products Affected

- VESICARE

ST Criteria	Documented trial of 1 preferred generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin)
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

Vestura

Products Affected

- VESTURA

QL Criteria	1.5 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viberzi

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Covered Uses	Diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	No known or suspected history of any of the following: diagnosis of pancreatitis, diagnosis of alcoholism, member drinks more than 3 alcoholic beverages/day, severe (Child-Pugh C) hepatic impairment, or anatomic or biochemical abnormalities of the gastrointestinal tract (e.g., biliary duct obstruction, sphincter of Oddi dysfunction, or severe constipation)
Required Medical Information	
Age Restrictions	A documented diagnosis of diarrhea-predominant irritable bowel syndrome (IBS)
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
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

Victoza

Products Affected

- VICTOZA SUBCUTANEOUS*

QL Criteria	1 box-2 or 3 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viekira Pak

Products Affected

- VIEKIRA PAK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Notes/References	
Revision Date	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
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
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

Viibryd

Products Affected

- VIIBRYD ORAL TABLET

QL Criteria	1 tab Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd

Products Affected

- VIIBRYD ORAL TABLET

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimizim

Products Affected

- VIMIZIM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected

- VIMPAT ORAL SOLUTION

QL Criteria	40 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected

- VIMPAT ORAL TABLET

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viokace

Products Affected

- VIOKACE

ST Criteria	Documented step through CREON AND ZENPEP
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viramune XR

Products Affected

- VIRAMUNE XR ORAL TABLET
EXTENDED RELEASE 24 HR* 400 MG

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viramune XR

Products Affected

- VIRAMUNE XR ORAL TABLET
EXTENDED RELEASE 24 HR* 100 MG

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viread

Products Affected

- VIREAD ORAL TABLET

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vistogard

Products Affected

- VISTOGARD

QL Criteria	20 packs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Visudyne

Products Affected

- VISUDYNE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vituz

Products Affected

- VITUZ

QL Criteria	120 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vivelle-Dot

Products Affected

- VIVELLE-DOT

QL Criteria	8 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vivlodex

Products Affected

- VIVLODEX

ST Criteria	Trial of one month each of two generic non steroidal anti-inflammatory drugs
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vogelxo

Products Affected

- VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	10 grams Per 1 day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

Vogelxo Pump

Products Affected

- VOGELXO PUMP

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	patient with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through one month of Androgel 1.62%
QL Criteria	10 grams Per 1 fill
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Voltaren

Products Affected

- VOLTAREN TRANSDERMAL

QL Criteria	200 GM Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vonvendi

Products Affected

- VONVENDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Votrient

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vpriv

Products Affected

- VPRIV

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 6 MG, 4.5 MG

ST Criteria	Trial of 1 month each of : 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 1.5 MG

ST Criteria	Trial of 1 month each of : 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	4 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vraylar

Products Affected

- VRAYLAR ORAL

ST Criteria	Trial of 1 month each of : 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 3 MG

ST Criteria	Trial of 1 month each of : 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vytorin

Products Affected

- VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vytorin

Products Affected

- VYTORIN ORAL TABLET 10-80 MG

ST Criteria	A documented step through one generic statin medication (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) and Zetia
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyvanse

Products Affected

- VYVANSE

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wellbutrin

Products Affected

- WELLBUTRIN ORAL TABLET 100 MG

QL Criteria	6 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wellbutrin SR

Products Affected

- WELLBUTRIN SR

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wellbutrin XL

Products Affected

- WELLBUTRIN XL

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wera

Products Affected

- WERA

QL Criteria	1.5 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wilate

Products Affected

- WILATE INTRAVENOUS* SOLUTION RECONSTITUTED 1000-1000 UNIT, 500-500 UNIT
- WILATE INTRAVENOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wymzya Fe

Products Affected

- WYMZYA FE

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xalatan

Products Affected

- XALATAN

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	Documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	A documented step through one week of latanoprost and one week of Travatan Z
Notes/References	
Revision Date	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xanax XR

Products Affected

- XANAX XR

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xartemis XR

Products Affected

- XARTEMIS XR

ST Criteria	Documented step through TWO of the following: MORPHINE, OXYCODONE, HYDROMORPHONE
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeljanz

Products Affected

- XELJANZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeljanz XR

Products Affected

- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeloda

Products Affected

- XELODA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xenazine

Products Affected

- XENAZINE ORAL TABLET 12.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xenazine

Products Affected

- XENAZINE ORAL TABLET 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeomin

Products Affected

- XEOMIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 200 MG

QL Criteria	9 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HR* 5-500 MG, 10-1000 MG, 10-500 MG

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED
RELEASE 24 HR* 5-1000 MG

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical 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

Xopenex HFA

Products Affected

- XOPENEX HFA

ST Criteria	Documented step through one week each of VENTOLIN HFA AND PROAIR
QL Criteria	2 inhalers Per 1 fill
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 09, 2016 Quantity Limits: August 25, 2015

Xtampza ER

Products Affected

- XTAMPZA ER

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	2 tablets Per 1 day
Notes/References	
Revision Date	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: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xulane

Products Affected

- XULANE

QL Criteria	3 patches Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xuriden

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyntha

Products Affected

- XYNTHA INTRAVENOUS* KIT 1000 UNIT, 2000 UNIT, 500 UNIT, 250 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyntha Solofuse

Products Affected

- XYNTHA SOLOFUSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Cataplexy associated with narcolepsy
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	Sleep specialist, pulmonologist, neurologist, or psychiatrist
Coverage Duration	3 months, extended approval based on therapeutic response
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: October 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyzal

Products Affected

- XYZAL

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

Xyzal

Products Affected

- XYZAL

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Yasmin 28

Products Affected

- YASMIN 28

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

YAZ

Products Affected

- YAZ

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zarah

Products Affected

- ZARAH

QL Criteria	1.5 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zarxio

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zavesca

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
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

Products Affected

- ZECUITY

QL Criteria	4 patches Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid

Products Affected

- ZEGERID ORAL CAPSULE

ST Criteria	A. Documentation of trial and failure of Nexium AND ONE of the following: Prilosec OTC/ Prilosec*, Prevacid 24H OTC, Zegerid OTC, or Protonix*
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid

Products Affected

- ZEGERID ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 packet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid OTC

Products Affected

- ZEGERID OTC

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 cap Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zelapar

Products Affected

- ZELAPAR

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zemaira

Products Affected

- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	pending
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	pending
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zembrace SymTouch

Products Affected

- ZEMBRACE SYMTOUCH

ST Criteria	Documented trial and failure of generic Imitrex injection
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

Zemplar

Products Affected

- ZEMPLAR ORAL CAPSULE 2 MCG, 1 MCG

QL Criteria	1 cap Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenatane

Products Affected

- ZENATANE ORAL CAPSULE 30 MG
- zenatane oral capsule 20 mg, 10 mg, 40 mg*

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring and member is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	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.
ST Criteria	Documented step through ONE GENERIC ORAL ANTIBIOTIC prescribed for treatment of acne (i.e., MINOCYCLINE OR DOXYCYCLINE)
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenchant

Products Affected

- ZENCHENT

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenchant FE

Products Affected

- ZENCHENT FE

QL Criteria	1.5 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenzedi

Products Affected

- ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 7.5 MG, 30 MG

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	
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenzedi

Products Affected

- ZENZEDI ORAL TABLET 5 MG, 10 MG

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	
QL Criteria	4 tabs Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zepatier

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
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

Zetia

Products Affected

- ZETIA

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

Zetonna

Products Affected

- ZETONNA

ST Criteria	adequate trial of 2 weeks each of 1 of the following: trial of Flonase OR Nasalide OR Nasacort 24HR OTC AND Nasonex
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziana

Products Affected

- ZIANA

ST Criteria	Documented step through RETIN-A*
Notes/ References	
Revision Date	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: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
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

Products Affected

- ZIOPTAN

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	Documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	A documented step through one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2016
Revision Date	Prior Authorization: May 28, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziprasidone HCl

Products Affected

- *ziprasidone hcl*

QL Criteria	2 caps Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zocor

Products Affected

- ZOCOR

QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zofran

Products Affected

- ZOFRAN ORAL SOLUTION

QL Criteria	50 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zofran

Products Affected

- ZOFRAN ORAL TABLET

QL Criteria	60 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zofran ODT

Products Affected

- ZOFRAN ODT

QL Criteria	60 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zohydro ER

Products Affected

- ZOHYDRO ER ORAL

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	2 capsules 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

Zoladex

Products Affected

- ZOLADEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoledronic Acid

Products Affected

- *zoledronic acid*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 2.5 mg*

QL Criteria	6 tabs Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet dispersible 2.5 mg*

QL Criteria	6 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet dispersible 5 mg*
- *zolmitriptan oral tablet 5 mg*

QL Criteria	30 tablet Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 100 MG

QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoloft

Products Affected

- ZOLOFT ORAL CONCENTRATE

QL Criteria	10 ML Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 50 MG

QL Criteria	1.5 tag Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 25 MG

QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate oral*

QL Criteria	2 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomacton

Products Affected

- ZOMACTON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zometa

Products Affected

- ZOMETA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- ZOMIG

QL Criteria	6 sprays Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- ZOMIG

QL Criteria	6 tabs Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig ZMT

Products Affected

- ZOMIG ZMT

QL Criteria	6 tabs Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zontivity

Products Affected

- ZONTIVITY

QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zorbtive

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zorvolex

Products Affected

- ZORVOLEX

QL Criteria	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovia 1/35E (28)

Products Affected

- ZOVIA 1/35E (28)

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovia 1/50E (28)

Products Affected

- ZOVIA 1/50E (28)

QL Criteria	1.5 tabs Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET
SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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 day
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 8.6-2.1 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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	2 tablets 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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET
SUBLINGUAL 11.4-2.9 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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	1 tablet 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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET
SUBLINGUAL 2.9-0.71 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence. NOTE: Prior Authorization does not apply to members residing in Massachusetts.
Exclusion Criteria	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.
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

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 http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. 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 tablets 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

Zurampic

Products Affected

- ZURAMPIC

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperuricemia associated with gout
Exclusion Criteria	
Required Medical Information	A documented diagnosis of gout, and will be used in combination with a xanthine oxidase inhibitor (allopurinol OR febuxostat)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through allopurinol or febuxostat
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

Zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zykadia

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZyPREXA

Products Affected

- ZYPREXA ORAL

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZyPREXA Zydys

Products Affected

- ZYPREXA ZYDIS

ST Criteria	A documented step through one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	1 tab Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zytiga

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyvox

Products Affected

- ZYVOX ORAL TABLET

QL Criteria	28 tabs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyvox

Products Affected

- ZYVOX ORAL SUSPENSION
RECONSTITUTED

QL Criteria	150 ml Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Index

ABILIFY DISCMELT	3	ADVICOR ORAL TABLET EXTENDED	
ABILIFY ORAL SOLUTION	2	RELEASE 24 HR* 500-20 MG, 750-20 MG,	
ABILIFY ORAL TABLET	1	1000-40 MG	42
ABSORICA	4	<i>adynovate</i>	44
ABSORICA	5	ADZENYS XR-ODT	45
ABSTRAL	6	AEROCHAMBER MV	46
ABSTRAL	8	AEROSPAN	47
<i>acamprosate calcium</i>	10	AFEDITAB CR ORAL TABLET EXTENDED	
ACCU-CHEK AVIVA IN VITRO STRIP	11	RELEASE 24 HR* 30 MG	49
ACCU-CHEK SMARTVIEW	12	AFEDITAB CR ORAL TABLET EXTENDED	
ACIPHEX	13	RELEASE 24 HR* 60 MG	48
ACIPHEX SPRINKLE	14	AFINITOR	50
<i>acitretin oral capsule 25 mg, 10 mg</i>	15	AFINITOR DISPERZ	51
ACTEMRA INTRAVENOUS*	16	AFREZZA INHALATION POWDER 4 (90) & 8	
ACTEMRA SUBCUTANEOUS*	17	(90) UNIT	52
ACTICLATE	18	AFREZZA INHALATION POWDER 4 UNIT, 4	
ACTICLATE	19	(30) & 8 (60) UNIT, 4 (60) & 8 (30) UNIT, 8	
ACTIMMUNE	20	(60)& 12 (30) UNIT	53
ACTIQ	21	AFSTYLA	54
ACTIVELLA	22	AKYNZEO	55
ACTONEL ORAL TABLET 150 MG	25	ALDARA	56
ACTONEL ORAL TABLET 35 MG	24	ALDURAZYME	57
ACTONEL ORAL TABLET 5 MG, 30 MG	23	ALECENSA	58
ACTOPLUS MET	26	<i>alendronate sodium oral solution</i>	61
ACTOPLUS MET XR	27	<i>alendronate sodium oral tablet 10 mg</i>	62
ACTOS	28	<i>alendronate sodium oral tablet 35 mg, 70 mg</i>	60
ADALAT CC ORAL TABLET EXTENDED		<i>alendronate sodium oral tablet 5 mg, 40 mg</i>	59
RELEASE 24 HR* 60 MG	29	<i>alfuzosin hcl er</i>	63
ADALAT CC ORAL TABLET EXTENDED		ALLEGRA ALLERGY ORAL TABLET 180 MG	
RELEASE 24 HR* 90 MG, 30 MG	30	.....	64
ADCIRCA	31	ALLEGRA ALLERGY ORAL TABLET 60 MG	
ADDERALL	32	.....	65
ADDERALL XR	33	<i>almotriptan malate</i>	66
<i>adefovir dipivoxil</i>	34	<i>alogliptin benzoate</i>	67
ADEMPAS	35	<i>alogliptin-metformin hcl</i>	68
ADRENACLICK INJECTION	36	<i>alogliptin-pioglitazone</i>	69
ADVAIR DISKUS INHALATION AEROSOL		ALORA	70
POWDER, BREATH ACTIVATED 100-50		<i>alosetron hcl</i>	71
MCG/DOSE	37	ALPHANATE/VWF COMPLEX/HUMAN	72
ADVAIR DISKUS INHALATION AEROSOL		ALPHANINE SD	73
POWDER, BREATH ACTIVATED 250-50		<i>alprazolam er</i>	74
MCG/DOSE	38	<i>alprazolam xr</i>	75
ADVAIR DISKUS INHALATION AEROSOL		ALPROLIX	76
POWDER, BREATH ACTIVATED 500-50		ALTAVERA	77
MCG/DOSE	39	ALTOPREV	78
ADVAIR HFA	40	ALVESCO	79
ADVATE	41	<i>alyacen 1/35</i>	80
ADVICOR ORAL TABLET EXTENDED		<i>alyacen 7/7/7</i>	81
RELEASE 24 HR* 1000-20 MG	43	AMBIEN	82

AMBIEN CR	83	ARAVA	120
AMERGE	84	ARCALYST	121
AMETHIA	85	ARCAPTA NEOHALER	122
AMETHIA LO	86	ARICEPT	123
AMETHYST	87	<i>aripiprazole oral solution</i>	124
AMITIZA	88	<i>aripiprazole oral tablet</i>	125
<i>amlodipine besylate-valsartan</i>	89	<i>aripiprazole oral tablet dispersible</i>	125
<i>amlodipine-valsartan-hctz</i>	90	ARIXTRA	126
<i>amphetamine salt combo</i>	91	<i>armodafinil oral tablet 200 mg, 250 mg, 150 mg</i>	127
<i>amphetamine-dextroamphet er</i>	92		128
<i>amphetamine-dextroamphetamine</i>	93	<i>armodafinil oral tablet 50 mg</i>	128
AMPYRA	94	ARNUITY ELLIPTA	129
ANDRODERM TRANSDERMAL PATCH 24 HR		ASACOL HD	130
2 MG/24HR, 4 MG/24HR	95	ASTAGRAF XL ORAL CAPSULE EXTENDED	
ANDRODERM TRANSDERMAL PATCH 24 HR		RELEASE 24 HOUR 0.5 MG	131
2.5 MG/24HR, 5 MG/24HR	96	ASTAGRAF XL ORAL CAPSULE EXTENDED	
ANDROGEL PUMP TRANSDERMAL GEL 12.5		RELEASE 24 HOUR 1 MG	132
MG/ACT (1%)	101	ATACAND	133
ANDROGEL PUMP TRANSDERMAL GEL		ATACAND HCT	134
20.25 MG/ACT (1.62%)	102	ATELVIA	135
ANDROGEL TRANSDERMAL GEL 20.25		<i>atorvastatin calcium oral</i>	136
MG/1.25GM (1.62%)	100	ATRIPLA	137
ANDROGEL TRANSDERMAL GEL 25		ATROVENT	138
MG/2.5GM (1%)	97	AUBAGIO	139
ANDROGEL TRANSDERMAL GEL 40.5		AVALIDE ORAL TABLET 150-12.5 MG,	
MG/2.5GM (1.62%)	98	300-12.5 MG	140
ANDROGEL TRANSDERMAL GEL 50		AVANDIA ORAL TABLET 4 MG, 2 MG	141
MG/5GM (1%)	99	AVAPRO	142
ANGELIQ	103	AVIANE	143
ANORO ELLIPTA	104	AVINZA	144
ANTARA ORAL CAPSULE 30 MG, 90 MG	105	<i>avita</i>	145
ANZEMET ORAL	106	AVODART	146
<i>apap-caff-dihydrocodeine oral capsule</i>	107	AVONEX	147
APIDRA	108	AVONEX PEN INTRAMUSCULAR*	148
APIDRA SOLOSTAR SUBCUTANEOUS*	109	AVONEX PREFILLED INTRAMUSCULAR*	
APRI	110		149
APRISO	111	AXERT	150
APTENSIO XR	112	AXIRON	151
APTIOM ORAL TABLET 200 MG	113	AZILECT	152
APTIOM ORAL TABLET 400 MG	116	AZOR	153
APTIOM ORAL TABLET 600 MG	114	AZULFIDINE	154
APTIOM ORAL TABLET 800 MG	115	AZULFIDINE EN-TABS	155
ARALAST NP INTRAVENOUS* SOLUTION		AZURETTE	156
RECONSTITUTED 1000 MG, 500 MG, 800 MG		<i>balsalazide disodium</i>	157
	117	BALZIVA	158
ARANELLE	118	BANZEL ORAL TABLET	159
ARANESP (ALBUMIN FREE) INJECTION	119	BARACLUDE ORAL TABLET	160
ARANESP (ALBUMIN FREE) INJECTION		BAYER CONTOUR NEXT TEST	161
SOLUTION 10 MCG/0.4ML, 60 MCG/ML, 150		BAYER CONTOUR TEST	162
MCG/0.75ML, 25 MCG/ML, 300 MCG/ML, 40		BEBULIN	163
MCG/ML, 100 MCG/ML, 200 MCG/ML	119	BECONASE AQ	164

BELBUCA	165	BYETTA 5 MCG PEN SUBCUTANEOUS*	217
BELSOMRA	166	BYSTOLIC ORAL TABLET 2.5 MG, 10 MG, 5	
BENEFIX INTRAVENOUS* SOLUTION		MG	219
RECONSTITUTED	167	BYSTOLIC ORAL TABLET 20 MG	218
BENICAR	168	BYVALSON	220
BENICAR HCT	169	CABOMETYX	221
BENLYSTA	170	<i>calcipotriene external cream</i>	222
BERINERT	171	<i>calcipotriene external ointment</i>	222
BETASERON SUBCUTANEOUS* KIT	172	<i>calcipotriene-betameth diprop</i>	223
BETHKIS	173	<i>calcitonin (salmon)</i>	224
BEVESPI AEROSPHERE	174	<i>calcitrene</i>	225
BEYAZ	175	CAMRESE	226
<i>bicalutamide</i>	176	CAMRESE LO	227
<i>bimatoprost ophthalmic</i>	177	CANASA	228
BIVIGAM	178	<i>candesartan cilexetil</i>	229
BONIVA INTRAVENOUS*	179	<i>candesartan cilexetil-hctz</i>	230
BONIVA ORAL TABLET 150 MG	180	<i>capecitabine</i>	231
BOSULIF	181	CAPRELSA ORAL TABLET 100 MG	233
BOTOX	182	CAPRELSA ORAL TABLET 300 MG	232
BREO ELLIPTA	183	CARBAGLU	234
BREO ELLIPTA	184	CARDIZEM CD ORAL CAPSULE EXTENDED	
BREVICON (28)	185	RELEASE 24 HOUR 240 MG	236
<i>briellyn</i>	186	CARDIZEM CD ORAL CAPSULE EXTENDED	
BRILINTA	187	RELEASE 24 HOUR 360 MG, 300 MG, 120 MG,	
BRILINTA	188	180 MG	235
BRINTELLIX	189	CARDIZEM LA ORAL TABLET EXTENDED	
BRISDELLE	190	RELEASE 24 HR* 120 MG, 180 MG, 420 MG,	
BRIVIACT ORAL SOLUTION	191	300 MG, 360 MG	237
BRIVIACT ORAL TABLET	192	CARDIZEM LA ORAL TABLET EXTENDED	
BROVANA	193	RELEASE 24 HR* 240 MG	238
<i>budesonide inhalation</i>	194	CARDURA XL	239
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	197	CARIMUNE NF INTRAVENOUS* SOLUTION	
BUNAVAIL BUCCAL FILM 4.2-0.7 MG	199	RECONSTITUTED 12 GM, 6 GM	240
BUNAVAIL BUCCAL FILM 6.3-1 MG	195	CARTIA XT ORAL CAPSULE EXTENDED	
BUPHENYL ORAL POWDER 3 GM/TSP	201	RELEASE 24 HOUR 180 MG, 120 MG, 300 MG	
BUPHENYL ORAL TABLET	201	.....	241
<i>buprenorphine hcl sublingual tablet sublingual</i> 2		CARTIA XT ORAL CAPSULE EXTENDED	
<i>mg</i>	202	RELEASE 24 HOUR 240 MG	242
<i>buprenorphine hcl sublingual tablet sublingual</i> 8		CASODEX	243
<i>mg</i>	204	CAYSTON	244
<i>buprenorphine hcl-naloxone hcl</i>	206	CAZANT	245
BUPROBAN	208	CELEBREX	246
<i>bupropion hcl er (smoking det)</i>	210	<i>celecoxib oral</i>	247
<i>bupropion hcl er (sr)</i>	211	CELEXA ORAL TABLET	248
<i>bupropion hcl er (xl)</i>	212	CENESTIN ORAL TABLET 0.3 MG	249
<i>bupropion hcl oral</i>	209	CERDELGA	250
<i>butorphanol tartrate nasal</i>	213	CEREZYME INTRAVENOUS* SOLUTION	
BUTRANS	214	RECONSTITUTED 400 UNIT	251
BYDUREON SUBCUTANEOUS* 2 MG	215	CESAMET	252
BYETTA 10 MCG PEN SUBCUTANEOUS*		CHANTIX	253
.....	216	CHANTIX CONTINUING MONTH PAK	254

CHANTIX STARTING MONTH PAK	255	COPAXONE SUBCUTANEOUS* 40 MG/ML	296
CHATEAL	256	CORDRAN EXTERNAL TAPE	298
CHENODAL	257	COREG CR	299
CHOLBAM	258	CORIFACT	300
CIALIS ORAL TABLET 2.5 MG	260	CORLANOR	301
CIALIS ORAL TABLET 5 MG	259	COSENTYX	302
CIMZIA PREFILLED	262	COSENTYX SENSOREADY PEN	
CIMZIA STARTER KIT	263	SUBCUTANEOUS* 150 MG/ML	303
CIMZIA SUBCUTANEOUS* KIT 2 X 200 MG		COTELLIC	304
.....	261	COZAAR ORAL TABLET 50 MG, 25 MG	305
CINQAIR	264	CRESTOR	306
CINRYZE	265	CRYSSELLE-28	307
<i>citalopram hydrobromide oral tablet</i>	266	CUPRIMINE ORAL CAPSULE 250 MG	308
<i>citalopram hydrobromide oral tablet</i>	267	CUVITRU	309
<i>claravis</i>	268	CYCLAFEM 1/35	310
CLARINEX ORAL TABLET	269	CYCLESSA	311
CLARINEX-D 12 HOUR	270	CYCLOSET	312
CLIMARA	271	CYMBALTA ORAL CAPSULE DELAYED	
CLIMARA PRO	272	RELEASE PARTICLES 20 MG	313
<i>clonidine hcl er</i>	273	CYMBALTA ORAL CAPSULE DELAYED	
<i>clopidogrel bisulfate</i>	274	RELEASE PARTICLES 30 MG	315
<i>clopidogrel bisulfate</i>	275	CYMBALTA ORAL CAPSULE DELAYED	
<i>clozapine oral tablet 100 mg</i>	276	RELEASE PARTICLES 60 MG	314
<i>clozapine oral tablet 200 mg</i>	280	CYSTADANE	316
<i>clozapine oral tablet 25 mg, 50 mg</i>	277	CYSTARON	317
<i>clozapine oral tablet dispersible 100 mg</i>	276	CYSTARAN	318
<i>clozapine oral tablet dispersible 12.5 mg</i>	278	DAKLINZA	319
<i>clozapine oral tablet dispersible 150 mg</i>	279	DAKLINZA	320
<i>clozapine oral tablet dispersible 200 mg</i>	281	DALIRESP	321
<i>clozapine oral tablet dispersible 25 mg</i>	277	<i>darifenacin hydrobromide er</i>	322
CLOZARIL ORAL TABLET 100 MG	283	DASETTA 1/35	323
CLOZARIL ORAL TABLET 25 MG	282	DASETTA 7/7/7	324
COAGADEX	284	DAYSEE	325
COLAZAL	285	DAYTRANA	326
<i>colchicine oral tablet</i>	286	DELZICOL	327
COLCRYS	287	DEPEN TITRATABS	328
COLYTE WITH FLAVOR PACKS ORAL		DEPO-PROVERA INTRAMUSCULAR*	
SOLUTION RECONSTITUTED 240 GM	288	SUSPENSION 150 MG/ML	329
COMBIPATCH	289	DEPO-SUBQ PROVERA 104	
COMETRIQ (100 MG DAILY DOSE)	290	SUBCUTANEOUS* SUSPENSION	330
COMETRIQ (140 MG DAILY DOSE)	291	DESCOVY	331
COMETRIQ (60 MG DAILY DOSE)	292	<i>desloratadine</i>	332
COMPLERA	293	DESOGEN	333
CONCERTA ORAL TABLET		<i>desogestrel-ethinyl estradiol oral tablet 0.15-30</i>	
EXTENDEDRELEASE* 27 MG, 18 MG, 54 MG		<i>mg-mcg</i>	334
.....	294	DESOXYN	335
CONCERTA ORAL TABLET		<i>desvenlafaxine er</i>	336
EXTENDEDRELEASE* 36 MG	295	<i>desvenlafaxine fumarate er</i>	337
COPAXONE SUBCUTANEOUS* 20 MG/ML		DETROL LA	338
.....	297		

DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR.....	340	<i>drospirenone-ethinyl estradiol oral tablet 3-0.03</i> mg.....	375
DEXEDRINE ORAL TABLET.....	339	DUAVEE.....	376
DEXILANT.....	341	DUETACT.....	377
<i>dexmethylphenidate hcl</i>	342	DUEXIS.....	378
<i>dexmethylphenidate hcl er</i>	343	DULERA.....	379
<i>dextroamphetamine sulfate er</i>	346	<i>duloxetine hcl oral capsule delayed release</i> <i>particles 20 mg</i>	381
<i>dextroamphetamine sulfate oral solution</i>	344	<i>duloxetine hcl oral capsule delayed release</i> <i>particles 30 mg, 40 mg</i>	380
<i>dextroamphetamine sulfate oral tablet</i>	345	<i>duloxetine hcl oral capsule delayed release</i> <i>particles 60 mg</i>	382
DIASSTAT ACUDIAL.....	347	DURAGESIC-100.....	383
DIASSTAT PEDIATRIC.....	348	DURAGESIC-12.....	384
<i>diazepam gel</i>	349	DURAGESIC-25.....	385
DIBENZYLINE.....	350	DURAGESIC-50.....	386
DICLEGIS.....	351	DURAGESIC-75.....	387
<i>diclofenac sodium transdermal gel 1 %</i>	353	<i>dutasteride</i>	388
<i>diclofenac sodium transdermal solution</i>	352	DYANA VEL XR.....	389
DIFFERIN EXTERNAL GEL.....	354	DYSPORT.....	390
DIFFERIN EXTERNAL LOTION.....	354	EDARBI.....	391
DIFICID.....	355	EDARBYCLOR.....	392
<i>dihydroergotamine mesylate nasal</i>	356	EDURANT.....	393
<i>diltiazem hcl er beads oral capsule extended</i> <i>release 24 hour 120 mg, 300 mg, 360 mg, 180 mg</i>	358	EFFEXOR XR.....	394
<i>diltiazem hcl er beads oral capsule extended</i> <i>release 24 hour 240 mg</i>	359	EFFIENT.....	395
<i>diltiazem hcl er coated beads oral capsule</i> <i>extended release 24 hour 240 mg</i>	362	ELAPRASE.....	396
<i>diltiazem hcl er coated beads oral capsule</i> <i>extended release 24 hour 300 mg, 120 mg, 180 mg,</i> <i>360 mg</i>	360	ELELYSO.....	397
<i>diltiazem hcl er coated beads oral tablet extended</i> <i>release 24 hr* 240 mg</i>	363	ELESTRIN.....	398
<i>diltiazem hcl er coated beads oral tablet extended</i> <i>release 24 hr* 360 mg, 420 mg, 180 mg, 300 mg</i>	361	ELIDEL.....	399
<i>diltiazem hcl er oral capsule extended release 24</i> <i>hour 240 mg</i>	357	ELIGARD.....	400
DIOVAN.....	364	ELINEST.....	401
DIOVAN HCT.....	365	ELLA.....	402
DIPENTUM.....	366	ELOCTATE.....	403
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HR* 10 MG, 15 MG.....	367	EMBEDA.....	404
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HR* 5 MG.....	368	EMEND ORAL CAPSULE 80 & 125 MG.....	406
DOLOPHINE.....	369	EMEND ORAL CAPSULE 80 MG, 40 MG, 125 MG.....	405
<i>donepezil hcl</i>	370	EMLA.....	407
DORYX MPC.....	371	EMOQUETTE.....	409
DOVONEX EXTERNAL CREAM.....	372	EMSAM.....	410
<i>doxycycline</i>	373	EMTRIVA ORAL CAPSULE.....	411
<i>dronabinol</i>	374	ENABLEX.....	412
		ENBREL SUBCUTANEOUS* 25 MG/0.5ML	414
		ENBREL SUBCUTANEOUS* 50 MG/ML.....	413
		ENBREL SURECLICK SUBCUTANEOUS*	415
		ENJUVIA.....	416
		<i>enoxaparin sodium</i>	417
		ENPRESSE-28.....	418
		ENSKYCE.....	419

<i>entecavir</i>	420	FANAPT TITRATION PACK.....	466
ENTRESTO.....	421	FARXIGA.....	467
ENTYVIO.....	422	FARYDAK.....	468
EPANED.....	423	FASLODEX INTRAMUSCULAR* SOLUTION	
EPCLUSA.....	424	250 MG/5ML.....	469
EPIDUO.....	425	FAZACLO ORAL TABLET DISPERSIBLE 100	
<i>epinephrine injection 0.15 mg/0.15ml</i>	426	MG.....	472
<i>epinephrine injection 0.3 mg/0.3ml</i>	427	FAZACLO ORAL TABLET DISPERSIBLE 12.5	
EPIPEN 2-PAK INJECTION.....	428	MG.....	473
EPIPEN JR 2-PAK INJECTION.....	429	FAZACLO ORAL TABLET DISPERSIBLE 150	
EPOGEN INJECTION SOLUTION 3000		MG.....	474
UNIT/ML, 2000 UNIT/ML, 10000 UNIT/ML,		FAZACLO ORAL TABLET DISPERSIBLE 200	
20000 UNIT/ML, 4000 UNIT/ML.....	430	MG.....	470
<i>epoprostenol sodium</i>	431	FAZACLO ORAL TABLET DISPERSIBLE 25	
<i>eprosartan mesylate</i>	432	MG.....	471
ERIVEDGE.....	433	FEIBA.....	475
ERRIN.....	434	<i>felodipine er</i>	476
ESBRIET.....	435	FEMCON FE.....	477
<i>escitalopram oxalate oral tablet 10 mg</i>	437	FEMHRT LOW DOSE.....	478
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	436	FEMRING.....	479
<i>esomeprazole magnesium</i>	438	<i>fenofibrate micronized</i>	483
ESTARYLLA.....	439	<i>fenofibrate micronized</i>	484
<i>estradiol transdermal patch biweekly</i>	440	<i>fenofibrate oral</i>	480
<i>estradiol transdermal patch weekly</i>	441	<i>fenofibrate oral</i>	481
<i>estradiol-norethindrone acet</i>	442	<i>fenofibrate oral</i>	482
<i>estradiol-norethindrone acet</i>	443	<i>fenofibric acid oral capsule delayed release</i>	485
ESTROGEL.....	444	FENOGLIDE.....	486
ESTROSTEP FE.....	445	<i>fentanyl citrate buccal</i>	489
<i>eszopiclone</i>	446	<i>fentanyl transdermal patch 72 hr 100 mcg/hr, 50</i>	
EUFLEXXA INTRA-ARTICULAR*.....	447	<i>mcg/hr, 25 mcg/hr, 12 mcg/hr, 75 mcg/hr</i>	487
EVAMIST.....	448	<i>fentanyl transdermal patch 72 hr 37.5 mcg/hr, 87.5</i>	
EVEKEO.....	449	<i>mcg/hr, 62.5 mcg/hr</i>	488
EVOXAC.....	450	FENTORA BUCCAL TABLET 100 MCG, 400	
EXALGO ORAL 16 MG.....	452	MCG, 800 MCG, 600 MCG, 200 MCG.....	490
EXALGO ORAL 32 MG, 12 MG, 8 MG.....	451	FERRIPROX.....	492
EXELON ORAL CAPSULE.....	453	FETZIMA.....	493
EXELON TRANSDERMAL.....	453	FETZIMA TITRATION.....	494
EXFORGE HCT.....	456	FIBRICOR.....	495
EXFORGE ORAL TABLET 10-320 MG, 5-320		FIRAZYR.....	496
MG.....	454	FIRMAGON.....	497
EXFORGE ORAL TABLET 5-160 MG, 10-160		FLEBOGAMMA DIF INTRAVENOUS*	
MG.....	455	SOLUTION 20 GM/400ML, 5 GM/100ML, 5	
EXJADE.....	457	GM/50ML, 2.5 GM/50ML, 10 GM/200ML, 0.5	
EXTAVIA SUBCUTANEOUS* KIT.....	458	GM/10ML.....	498
EYLEA.....	459	FLOLAN.....	499
FABIOR.....	460	FLOVENT DISKUS INHALATION AEROSOL	
FABRAZYME.....	461	POWDER, BREATH ACTIVATED 100	
FALMINA.....	462	MCG/BLIST.....	501
<i>famciclovir oral</i>	463	FLOVENT DISKUS INHALATION AEROSOL	
FAMVIR.....	464	POWDER, BREATH ACTIVATED 50	
FANAPT.....	465	MCG/BLIST, 250 MCG/BLIST.....	500

FLOVENT HFA.....	502	GATTEX.....	545
<i>fluocinonide external cream</i>	503	GELNIQUE.....	546
<i>fluoxetine hcl oral capsule 10 mg</i>	508	GEL-ONE INTRA-ARTICULAR*.....	547
<i>fluoxetine hcl oral capsule 20 mg</i>	509	GELSYN-3.....	548
<i>fluoxetine hcl oral capsule 40 mg</i>	507	GENERESS FE.....	549
<i>fluoxetine hcl oral capsule delayed release</i>	504	GENOTROPIN.....	550
<i>fluoxetine hcl oral tablet 10 mg</i>	505	GENOTROPIN MINIQUICK.....	551
<i>fluoxetine hcl oral tablet 20 mg</i>	510	GENVOYA.....	552
<i>fluoxetine hcl oral tablet 60 mg</i>	506	GEODON ORAL.....	553
<i>fluvastatin sodium</i>	511	GIANVI.....	554
<i>fluvastatin sodium er</i>	512	GIAZO.....	555
<i>fluvoxamine maleate er</i>	515	GILDAGIA.....	556
<i>fluvoxamine maleate oral tablet 100 mg</i>	514	GILDESS FE 1.5/30.....	557
<i>fluvoxamine maleate oral tablet 25 mg, 50 mg</i>	513	GILDESS FE 1/20.....	558
.....	513	GILENYA.....	559
FOCALIN.....	516	GILOTRIF.....	560
FOCALIN XR.....	517	GLASSIA.....	561
<i>fondaparinux sodium</i>	518	GLATOPA.....	562
FORADIL AEROLIZER.....	519	GLEEVEC ORAL TABLET 100 MG.....	563
FORTEO SUBCUTANEOUS* SOLUTION 600		GLEEVEC ORAL TABLET 400 MG.....	564
MCG/2.4ML.....	520	GLUCAGEN HYPOKIT.....	565
FORTESTA.....	521	GLYXAMBI.....	566
FORTICAL.....	522	GRALISE ORAL TABLET 300 MG.....	567
FOSAMAX ORAL TABLET 70 MG.....	523	GRALISE ORAL TABLET 600 MG.....	568
FOSAMAX PLUS D.....	524	GRALISE STARTER.....	569
FRAGMIN SUBCUTANEOUS* SOLUTION		GRANIX.....	570
15000 UNIT/0.6ML, 18000 UNT/0.72ML, 5000		<i>guanfacine hcl er</i>	571
UNIT/0.2ML, 95000 UNIT/3.8ML, 10000		HARVONI.....	572
UNIT/ML, 12500 UNIT/0.5ML, 2500		HELIXATE FS.....	573
UNIT/0.2ML, 7500 UNIT/0.3ML.....	525	HEMANGEOL.....	574
FREESTYLE INSULINX TEST.....	526	HEMOFIL M INTRAVENOUS* SOLUTION	
FREESTYLE LITE TEST.....	527	RECONSTITUTED 1000 UNIT, 1700 UNIT, 500	
FREESTYLE TEST.....	528	UNIT, 250 UNIT.....	575
FROVA.....	529	HEPSERA.....	576
<i>frovatriptan succinate</i>	530	HETLIOZ.....	577
FUZEON SUBCUTANEOUS* SOLUTION		HIZENTRA SUBCUTANEOUS* SOLUTION 2	
RECONSTITUTED.....	531	GM/10ML, 1 GM/5ML, 4 GM/20ML, 10	
FYCOMPA ORAL TABLET.....	532	GM/50ML.....	578
<i>gabapentin oral capsule</i>	534	HORIZANT ORAL TABLET	
<i>gabapentin oral solution 250 mg/5ml</i>	535	EXTENDEDRELEASE* 300 MG.....	579
<i>gabapentin oral tablet</i>	533	HORIZANT ORAL TABLET	
GABITRIL ORAL TABLET 16 MG.....	537	EXTENDEDRELEASE* 600 MG.....	580
GABITRIL ORAL TABLET 2 MG.....	538	HP ACTHAR.....	581
GABITRIL ORAL TABLET 4 MG, 12 MG.....	536	HUMATE-P INTRAVENOUS* SOLUTION	
<i>galantamine hydrobromide</i>	539	RECONSTITUTED 500-1200 UNIT, 1000-2400	
GAMMAGARD.....	540	UNIT, 250-600 UNIT.....	582
GAMMAGARD S/D LESS IGA.....	541	HUMATROPE.....	583
GAMMAKED.....	542	HUMIRA PEDIATRIC CROHNS START	
GAMMAPLEX INTRAVENOUS* SOLUTION 5		SUBCUTANEOUS* 40 MG/0.8ML.....	586
GM/100ML, 10 GM/200ML, 20 GM/400ML....	543	HUMIRA PEN SUBCUTANEOUS*.....	587
GAMUNEX-C.....	544		

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

HUMIRA PEN-CROHNS STARTER		INVOKAMET	625
SUBCUTANEOUS*	588	INVOKAMET XR	626
HUMIRA PEN-PSORIASIS STARTER		INVOKANA	627
SUBCUTANEOUS*	589	<i>ipratropium bromide nasal</i>	628
HUMIRA SUBCUTANEOUS* 20 MG/0.4ML, 10		IPRIVASK	629
MG/0.2ML	584	<i>irbesartan</i>	630
HUMIRA SUBCUTANEOUS* 40 MG/0.8ML		<i>irbesartan-hydrochlorothiazide</i>	631
	585	IRENKA	632
HYALGAN	590	IRESSA	633
HYCAMTIN ORAL	591	ISENTRESS ORAL TABLET	634
<i>hydromorphone hcl er oral 12 mg, 8 mg, 32 mg</i>		ISENTRESS ORAL TABLET CHEWABLE	635
	592	<i>itraconazole oral</i>	636
<i>hydromorphone hcl er oral 16 mg</i>	593	IXINITY	637
HYMOVIS	594	JADENU	638
HYQVIA	595	JAKAFI ORAL TABLET 10 MG	640
HYSINGLA ER	596	JAKAFI ORAL TABLET 5 MG, 25 MG, 15 MG,	
<i>ibandronate sodium intravenous* solution 3</i>		20 MG	639
<i>mg/3ml</i>	598	JANUMET	641
<i>ibandronate sodium oral</i>	597	JANUMET XR ORAL TABLET EXTENDED	
IBRANCE	599	RELEASE 24 HR* 50-1000 MG	643
ICLUSIG ORAL TABLET 15 MG	600	JANUMET XR ORAL TABLET EXTENDED	
ICLUSIG ORAL TABLET 45 MG	601	RELEASE 24 HR* 50-500 MG, 100-1000 MG	
IDELVION	602		642
ILARIS	603	JANUVIA	644
<i>imatinib mesylate</i>	604	JARDIANCE	645
IMBRUVICA	605	JENCYCLA	646
<i>imiquimod external</i>	606	JENTADUETO	647
IMITREX NASAL	607	JENTADUETO XR ORAL TABLET EXTENDED	
IMITREX ORAL	609	RELEASE 24 HR* 2.5-1000 MG	649
IMITREX STATDOSE REFILL		JENTADUETO XR ORAL TABLET EXTENDED	
SUBCUTANEOUS*	610	RELEASE 24 HR* 5-1000 MG	648
IMITREX SUBCUTANEOUS*	608	JETREA	650
IMPAVIDO	611	JOLESSA	651
INCRELEX	612	JOLIVETTE	652
INCRUSE ELLIPTA	613	JUBLIA	653
INLYTA	614	JUNEL 1.5/30	654
INNOPRAN XL ORAL CAPSULE EXTENDED		JUNEL 1/20	655
RELEASE 24 HOUR 120 MG	616	JUNEL FE 1.5/30	656
INNOPRAN XL ORAL CAPSULE EXTENDED		JUNEL FE 1/20	657
RELEASE 24 HOUR 80 MG	615	JUXTAPID ORAL CAPSULE 10 MG, 5 MG	658
INTELENCE ORAL TABLET 100 MG, 25 MG		JUXTAPID ORAL CAPSULE 20 MG	659
	617	JUXTAPID ORAL CAPSULE 40 MG, 30 MG, 60	
INTELENCE ORAL TABLET 200 MG	618	MG	660
INTERMEZZO	619	KADIAN	661
INTRON A	620	KADIAN	662
INTROVALE	621	KALBITOR	663
INTUNIV	622	KALYDECO	664
INVEGA ORAL TABLET EXTENDED		KALYDECO	665
RELEASE 24 HR* 6 MG, 3 MG, 1.5 MG	623	KANUMA	666
INVEGA ORAL TABLET EXTENDED		KAPVAY ORAL TABLET EXTENDED	
RELEASE 24 HR* 9 MG	624	RELEASE 12 HR*	667

KARIVA	668	<i>lamotrigine er oral tablet extended release 24 hr*</i>	
KAZANO	669	200 mg	707
KCENTRA	670	<i>lamotrigine er oral tablet extended release 24 hr*</i>	
KELNOR 1/35	671	250 mg, 300 mg	705
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR* 500 MG	672	<i>lamotrigine oral tablet dispersible 100 mg, 200 mg</i>	702
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR* 750 MG	673	<i>lamotrigine oral tablet dispersible 25 mg</i>	704
KERYDIN	674	<i>lamotrigine oral tablet dispersible 50 mg</i>	703
KETEK	675	<i>lansoprazole oral capsule delayed release 15 mg</i>	708
<i>ketoconazole oral</i>	676	LANTUS	709
<i>ketorolac tromethamine oral</i>	677	LANTUS SOLOSTAR SUBCUTANEOUS*	710
KEVEYIS	678	LATUDA ORAL TABLET 120 MG, 40 MG	713
KHEDEZLA	679	LATUDA ORAL TABLET 20 MG	712
KINERET SUBCUTANEOUS*	680	LATUDA ORAL TABLET 60 MG	714
KOATE-DVI	681	LATUDA ORAL TABLET 80 MG	711
KOGENATE FS	682	LAZANDA NASAL SOLUTION 100 MCG/ACT, 400 MCG/ACT	715
KOGENATE FS BIO-SET	683	LAZANDA NASAL SOLUTION 300 MCG/ACT	717
KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HR* 2.5-1000 MG	684	LEENA	719
KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HR* 5-1000 MG, 5-500 MG	685	<i>leflunomide oral</i>	720
KORLYM	686	LEMTRADA	721
KOVALTRY	687	LENVIMA 10 MG DAILY DOSE	722
KRYSTEXXA	688	LENVIMA 14 MG DAILY DOSE	723
KURVELO	689	LENVIMA 18 MG DAILY DOSE	724
KUVAN	690	LENVIMA 20 MG DAILY DOSE	725
KYNAMRO SUBCUTANEOUS*	691	LENVIMA 24 MG DAILY DOSE	726
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG	693	LENVIMA 8 MG DAILY DOSE	727
LAMICTAL ODT ORAL TABLET DISPERSIBLE 200 MG	692	LESCOL ORAL CAPSULE 20 MG	728
LAMICTAL ODT ORAL TABLET DISPERSIBLE 25 MG	694	LESCOL XL	729
LAMICTAL ODT ORAL TABLET DISPERSIBLE 50 MG	695	LESSINA	730
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 100 MG, 25 MG, 50 MG	697	LETAIRIS	731
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 200 MG	699	LEUKINE INTRAVENOUS*	732
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 250 MG	698	<i>leuprolide acetate injection</i>	733
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 300 MG	696	<i>levalbuterol tartrate hfa</i>	734
LAMISIL ORAL PACKET 125 MG	700	<i>levetiracetam er oral tablet extended release 24 hr* 500 mg</i>	735
LAMISIL ORAL PACKET 187.5 MG	701	<i>levetiracetam er oral tablet extended release 24 hr* 750 mg</i>	736
<i>lamotrigine er oral tablet extended release 24 hr* 100 mg, 25 mg, 50 mg</i>	706	<i>levocetirizine dihydrochloride oral tablet</i>	737
		LEVONEST	738
		<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg</i>	739
		<i>levonorgestrel oral tablet 1.5 mg</i>	740
		<i>levonorgestrel-ethinyl estrad</i>	741
		<i>levonorgestrel-ethinyl estrad</i>	742
		LEVORA 0.15/30 (28)	743
		LEXAPRO ORAL TABLET 10 MG	744
		LEXAPRO ORAL TABLET 20 MG, 5 MG	745
		LIALDA	746

LIDEX.....	747	MATZIM LA ORAL TABLET EXTENDED	
<i>lidocaine external ointment</i>	748	RELEASE 24 HR* 300 MG, 420 MG, 180 MG,	
<i>lidocaine-prilocaine external cream</i>	750	360 MG.....	796
<i>lindane external</i>	752	MAXALT.....	797
<i>linezolid oral suspension reconstituted</i>	753	MAXALT-MLT.....	798
<i>linezolid oral tablet</i>	754	<i>medroxyprogesterone acetate intramuscular*</i>	
LINZESS.....	755	<i>suspension</i>	799
LIPITOR.....	756	MEKINIST ORAL TABLET 0.5 MG.....	801
LIPOFEN.....	757	MEKINIST ORAL TABLET 2 MG.....	800
LIVALO.....	758	<i>memantine hcl oral tablet 5 (28)-10 (21) mg</i>	802
LO LOESTRIN FE.....	759	MENOSTAR.....	803
LOESTRIN 1.5/30 (21).....	760	<i>mesalamine oral</i>	804
LOESTRIN 1/20 (21).....	761	METADATE CD.....	805
LOESTRIN FE 1.5/30.....	762	METADATE ER ORAL TABLET	
LOESTRIN FE 1/20.....	763	EXTENDEDRELEASE* 20 MG.....	806
LOFIBRA.....	764	<i>methadone hcl oral solution 10 mg/5ml</i>	808
LOFIBRA.....	765	<i>methadone hcl oral solution 5 mg/5ml</i>	807
LOMEDIA 24 FE.....	766	<i>methadone hcl oral tablet</i>	809
LONSURF ORAL TABLET 15-6.14 MG.....	767	METHADOSE ORAL TABLET.....	810
LONSURF ORAL TABLET 20-8.19 MG.....	768	METHADOSE ORAL TABLET SOLUBLE.....	811
LORYNA.....	769	<i>methamphetamine hcl</i>	812
<i>losartan potassium oral tablet 50 mg, 25 mg</i>	770	METHYLIN ORAL SOLUTION 10 MG/5ML	
LOSEASONIQUE.....	771	.....	813
LOTRONEX.....	772	METHYLIN ORAL SOLUTION 5 MG/5ML.....	814
<i>lovastatin</i>	773	METHYLIN ORAL TABLET CHEWABLE.....	815
LOVAZA.....	774	<i>methylphenidate hcl er (cd)</i>	822
LOVENOX.....	775	<i>methylphenidate hcl er (la)</i>	823
LOW-OGESTREL.....	776	<i>methylphenidate hcl er oral tablet extended release</i>	
LUCENTIS.....	777	24 hr* 27 mg, 18 mg, 54 mg.....	820
LUMIGAN OPHTHALMIC SOLUTION 0.01 %		<i>methylphenidate hcl er oral tablet extended release</i>	
.....	778	24 hr* 36 mg.....	819
LUMIZYME.....	779	<i>methylphenidate hcl er oral tablet</i>	
LUNESTA.....	780	<i>extendedrelease* 20 mg</i>	821
LUPANETA PACK.....	781	<i>methylphenidate hcl er oral tablet</i>	
LUPRON DEPOT.....	782	<i>extendedrelease* 36 mg</i>	819
LUPRON DEPOT-PED.....	783	<i>methylphenidate hcl er oral tablet</i>	
LUTERA.....	784	<i>extendedrelease* 54 mg, 18 mg, 27 mg</i>	820
LYNPARZA.....	785	<i>methylphenidate hcl oral solution 10 mg/5ml</i>	818
LYSTEDA.....	786	<i>methylphenidate hcl oral solution 5 mg/5ml</i>	816
LYZA.....	787	<i>methylphenidate hcl oral tablet</i>	817
MACUGEN.....	788	<i>methylphenidate hcl oral tablet chewable</i>	817
MAKENA.....	789	<i>metoprolol succinate er oral tablet extended</i>	
<i>maprotiline hcl oral tablet 25 mg</i>	790	<i>release 24 hr* 100 mg, 50 mg</i>	824
<i>maprotiline hcl oral tablet 50 mg</i>	792	<i>metoprolol succinate er oral tablet extended</i>	
<i>maprotiline hcl oral tablet 75 mg</i>	791	<i>release 24 hr* 200 mg</i>	825
MARINOL.....	793	<i>metoprolol succinate er oral tablet extended</i>	
<i>marlissa</i>	794	<i>release 24 hr* 25 mg</i>	826
MATZIM LA ORAL TABLET EXTENDED		MEVACOR ORAL TABLET 40 MG.....	827
RELEASE 24 HR* 240 MG.....	795	MIACALCIN NASAL.....	828
		MICARDIS.....	829
		MICARDIS HCT.....	830

MICORT-HC	831	NATESTO	875
MICROGESTIN 1.5/30	832	NATPARA	876
MICROGESTIN 1/20	833	NECON 0.5/35 (28)	877
MICROGESTIN FE 1.5/30	834	NECON 1/35 (28)	878
MICROGESTIN FE 1/20	835	NECON 1/50 (28)	879
MIGRANAL	836	NECON 10/11 (28)	880
MIMVEY	837	NESINA	881
MINASTRIN 24 FE	838	NEULASTA SUBCUTANEOUS*	882
MINIVELLE	839	NEUPOGEN INJECTION	883
MIRAPEX ER	840	NEUPOGEN INJECTION SOLUTION 480	
MIRCERA INJECTION	841	MCG/1.6ML, 300 MCG/ML	883
MIRCETTE	842	NEUPRO	884
MIRENA (52 MG)	843	NEURONTIN ORAL CAPSULE	886
<i>mirtazapine oral</i>	844	NEURONTIN ORAL TABLET	885
MITIGARE	845	<i>nevirapine er oral tablet extended release 24 hr*</i>	
<i>modafinil</i>	846	<i>100 mg</i>	888
MODICON (28)	847	<i>nevirapine er oral tablet extended release 24 hr*</i>	
MONOCLATE-P INTRAVENOUS* KIT 1000		<i>400 mg</i>	887
UNIT, 1500 UNIT, 250 UNIT	848	NEXAVAR	889
MONO-LINYAH	849	NEXIUM	890
MONONESSA	850	NEXIUM	891
MONONINE	851	NEXIUM	892
MONOVISC	852	NEXPLANON	893
<i>montelukast sodium oral</i>	853	NEXT CHOICE ONE DOSE	894
<i>montelukast sodium oral</i>	854	<i>nicotine</i>	895
<i>morphine sulfate er beads</i>	858	<i>nicotine polacrilex mouth/throat gum</i>	896
<i>morphine sulfate er oral capsule extended release</i>		<i>nicotine polacrilex mouth/throat lozenge</i>	897
<i>24 hour</i>	856	NICOTROL	898
<i>morphine sulfate er oral tablet extended release*</i>		NICOTROL NS	899
	855	NIFEDICAL XL ORAL TABLET EXTENDED	
<i>morphine sulfate er oral tablet extended release*</i>		RELEASE 24 HR* 30 MG	900
	857	NIFEDICAL XL ORAL TABLET EXTENDED	
MOVANTIK	859	RELEASE 24 HR* 60 MG	901
MS CONTIN ORAL TABLET		<i>nifedipine er oral tablet extended release 24 hr* 30</i>	
EXTENDEDRELEASE*	860	<i>mg, 90 mg</i>	902
MS CONTIN ORAL TABLET		<i>nifedipine er oral tablet extended release 24 hr* 60</i>	
EXTENDEDRELEASE*	861	<i>mg</i>	903
MULTAQ	862	<i>nifedipine er osmotic release oral tablet extended</i>	
MYALEPT	863	<i>release 24 hr* 30 mg, 90 mg</i>	904
<i>myorisan oral capsule 20 mg, 40 mg, 10 mg</i>	864	<i>nifedipine er osmotic release oral tablet extended</i>	
MYRBETRIQ	865	<i>release 24 hr* 60 mg</i>	905
MYTESI	866	NINLARO	906
NAGLAZYME	867	<i>nisoldipine er oral tablet extended release 24 hr*</i>	
NAMENDA	868	<i>17 mg, 34 mg, 20 mg, 40 mg, 8.5 mg</i>	908
NAMENDA TITRATION PAK	869	<i>nisoldipine er oral tablet extended release 24 hr*</i>	
NAMENDA XR	870	<i>30 mg</i>	907
NAMENDA XR TITRATION PACK	871	NORA-BE	909
NAMZARIC ORAL CAPSULE EXTENDED		NORDITROPIN FLEXPPO SUBCUTANEOUS*	
RELEASE 24 HOUR	872	SOLUTION 15 MG/1.5ML, 10 MG/1.5ML, 5	
<i>naratriptan hcl</i>	873	MG/1.5ML	910
NATAZIA	874		

NORDITROPIN FLEXPEN SUBCUTANEOUS*	911	NYMALIZE	954
SOLUTION 30 MG/3ML	911	OCALIVA ORAL TABLET 5 MG	955
norethindrone oral	912	OCELLA	956
norethindrone-eth estradiol oral tablet 0.5-2.5	913	OCTAGAM	957
mg-mcg	913	octreotide acetate injection solution 1000 mcg/ml,	
norethin-eth estradiol-fe	914	50 mcg/ml, 200 mcg/ml, 500 mcg/ml, 100 mcg/ml	
norgestimate-eth estradiol oral tablet 0.25-35	915		958
mg-mcg	915	ODEFSEY	959
norgestim-eth estrad triphasic oral tablet		ODOMZO	960
0.18/0.215/0.25 mg-35 mcg	916	OFEV	961
NORINYL 1+35 (28)	917	OGESTREL	962
NORINYL 1+50 (28)	918	olanzapine oral tablet 15 mg, 10 mg, 5 mg, 20 mg,	
NOR-QD	919	7.5 mg	963
NORTHERA ORAL CAPSULE 200 MG, 100 MG	920	olanzapine oral tablet 2.5 mg	964
	920	olanzapine oral tablet dispersible 5 mg, 15 mg, 20	
NORTHERA ORAL CAPSULE 300 MG	921	mg	963
NORTREL 0.5/35 (28)	922	OLEPTRO ORAL TABLET EXTENDED	
NORTREL 1/35 (21)	923	RELEASE 24 HR* 150 MG	966
NORTREL 1/35 (28)	924	OLEPTRO ORAL TABLET EXTENDED	
NORTREL 7/7/7	925	RELEASE 24 HR* 300 MG	965
NOVA MAX GLUCOSE TEST	926	OLYSIO	967
NOVOEIGHT	927	omega-3-acid ethyl esters	968
NOVOLIN 70/30	928	omeprazole-sodium bicarbonate oral packet	969
NOVOLIN 70/30 RELION	929	OMNARIS	970
NOVOLIN N	930	OMNITROPE	971
NOVOLIN N RELION	931	ondansetron	972
NOVOLIN R	932	ondansetron hcl oral solution	974
NOVOLIN R RELION	933	ondansetron hcl oral tablet 24 mg	975
NOVOLOG	934	ondansetron hcl oral tablet 8 mg, 4 mg	973
NOVOLOG FLEXPEN SUBCUTANEOUS*	935	ONETOUCH ULTRA BLUE	976
NOVOLOG MIX 70/30	936	ONETOUCH VERIO IN VITRO STRIP	977
NOVOLOG MIX 70/30 FLEXPEN		ONETOUCH VERIO IQ SYSTEM	978
SUBCUTANEOUS*	937	ONEXTON	979
NOVOSEVEN RT	938	ONFI ORAL TABLET 10 MG, 20 MG	980
NOXAFIL ORAL TABLET DELAYED		ONGLYZA	981
RELEASE	939	ONZETRA XSAIL	982
NPLATE	940	OPANA ER ORAL	983
NUCALA	941	OPSUMIT	984
NUCYNTA	942	ORAMORPH SR ORAL TABLET	
NUCYNTA ER	943	EXTENDEDRELEASE* 15 MG	985
NUEDEXTA	944	ORAVIG	986
NUPLAZID	945	ORENCIA CLICKJECT	989
NUTROPIN AQ NUSPIN 10	946	ORENCIA INTRAVENOUS*	987
NUTROPIN AQ NUSPIN 20	947	ORENCIA SUBCUTANEOUS*	988
NUTROPIN AQ NUSPIN 5	948	ORENITRAM	990
NUTROPIN AQ PEN	949	ORFADIN	991
NUVARING	950	ORKAMBI	992
NUVIGIL ORAL TABLET 250 MG, 150 MG, 200		ORSYTHIA	993
MG	951	ORTHO MICRONOR	994
NUVIGIL ORAL TABLET 50 MG	952	ORTHO TRI-CYCLEN (28)	995
NUWIQ	953	ORTHO TRI-CYCLEN LO	996

ORTHO-CYCLEN (28)	997	PENNSAID TRANSDERMAL SOLUTION 2 %	1038
ORTHO-NOVUM 1/35 (28)	998	PENTASA ORAL CAPSULE EXTENDED	
ORTHO-NOVUM 7/7/7 (28)	999	RELEASE* 250 MG	1040
ORTHOVISC INTRA-ARTICULAR*	1000	PENTASA ORAL CAPSULE EXTENDED	
OSENI	1001	RELEASE* 500 MG	1039
OSPHENA	1002	PERFOROMIST	1041
OTEZLA ORAL 10 & 20 & 30 MG	1004	PERTZYE	1042
OTEZLA ORAL TABLET	1003	<i>phenoxybenzamine hcl oral</i>	1043
OTREXUP	1005	PHILITH	1044
OVCON-35 (28)	1006	PICATO	1045
OXTELLAR XR ORAL TABLET EXTENDED		<i>pioglitazone hcl</i>	1046
RELEASE 24 HR* 150 MG, 300 MG	1007	<i>pioglitazone hcl-glimepiride</i>	1047
OXTELLAR XR ORAL TABLET EXTENDED		<i>pioglitazone hcl-metformin hcl</i>	1048
RELEASE 24 HR* 600 MG	1008	PIRMELLA 1/35	1049
<i>oxybutynin chloride oral tablet</i>	1009	PLAN B ONE-STEP	1050
<i>oxycodone hcl er oral</i>	1010	PLAVIX	1051
<i>oxycodone hcl er oral</i>	1011	PLAVIX	1052
<i>oxycodone-ibuprofen</i>	1012	PLEGRIDY STARTER PACK	
OXYCONTIN ORAL	1013	SUBCUTANEOUS* 63 & 94 MCG/0.5ML	1055
<i>oxymorphone hcl er</i>	1014	PLEGRIDY STARTER PACK	
OXYTROL FOR WOMEN	1015	SUBCUTANEOUS* 63 & 94 MCG/0.5ML	1056
OZURDEX	1016	PLEGRIDY SUBCUTANEOUS* 125	
<i>paliperidone er oral tablet extended release 24 hr*</i>		MCG/0.5ML	1053
<i>1.5 mg, 6 mg, 3 mg</i>	1018	PLEGRIDY SUBCUTANEOUS* 125	
<i>paliperidone er oral tablet extended release 24 hr*</i>		MCG/0.5ML	1054
<i>9 mg</i>	1017	POMALYST	1057
<i>pamidronate disodium</i>	1019	PORTIA-28	1058
PANCREAZE ORAL CAPSULE DELAYED		POTIGA ORAL TABLET 200 MG	1059
RELEASE PARTICLES 10500-25000 UNIT,		POTIGA ORAL TABLET 400 MG, 300 MG	
21000-37000 UNIT, 16800-40000 UNIT,			1060
4200-10000 UNIT	1020	POTIGA ORAL TABLET 50 MG	1061
PARAGARD INTRAUTERINE COPPER	1021	PRADAXA	1062
<i>paricalcitol oral</i>	1022	PRALUENT	1063
<i>paroxetine hcl er</i>	1025	<i>pramipexole dihydrochloride er</i>	1064
<i>paroxetine hcl oral tablet 20 mg, 10 mg</i>	1023	PRAVACHOL ORAL TABLET 20 MG, 40 MG,	
<i>paroxetine hcl oral tablet 40 mg, 30 mg</i>	1024	80 MG	1065
PAXIL CR	1029	<i>pravastatin sodium</i>	1066
PAXIL ORAL SUSPENSION	1027	PRECISION XTRA BLOOD GLUCOSE	1067
PAXIL ORAL TABLET 10 MG, 20 MG	1026	PREFEST	1068
PAXIL ORAL TABLET 30 MG, 40 MG	1028	PRENATE MINI	1069
<i>peg 3350/electrolytes</i>	1030	PREVACID 24HR	1072
<i>peg-3350/electrolytes</i>	1031	PREVACID ORAL CAPSULE DELAYED	
PEGASYS PROCLICK	1033	RELEASE 15 MG	1070
PEGASYS SUBCUTANEOUS* SOLUTION		PREVACID ORAL CAPSULE DELAYED	
	1032	RELEASE 30 MG	1071
PEGINTRON	1034	PREVACID SOLUTAB	1073
PEG-INTRON	1035	PREVIFEM	1074
PEG-INTRON REDIPEN	1036	PREZISTA ORAL SUSPENSION	1075
PEG-INTRON REDIPEN PAK 4		PREZISTA ORAL TABLET 150 MG, 600 MG, 75	
SUBCUTANEOUS* KIT 120 MCG/0.5ML	1037	MG	1076

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

PREZISTA ORAL TABLET 800 MG	1077	<i>quetiapine fumarate oral tablet 400 mg, 300 mg</i>	
PRILOSEC	1078		1120
PRILOSEC	1079	QUILLIVANT XR	1122
PRISTIQ	1080	<i>quinine sulfate oral</i>	1123
PRISTIQ	1081	RA TRUETEST TEST	1124
PRIVIGEN	1082	<i>rabeprazole sodium</i>	1125
PROAIR RESPICLICK	1083	RANEXA	1126
PROCARDIA XL ORAL TABLET EXTENDED		RASUVO	1127
RELEASE 24 HR* 30 MG, 90 MG	1084	RAVICTI	1128
PROCARDIA XL ORAL TABLET EXTENDED		RAYOS	1129
RELEASE 24 HR* 60 MG	1085	RAZADYNE ORAL TABLET	1130
PROCENTRA	1086	REBIF REBIDOSE SUBCUTANEOUS*	1132
PROCRIT	1087	REBIF REBIDOSE TITRATION PACK	
PROCYSBI ORAL CAPSULE DELAYED		SUBCUTANEOUS*	1133
RELEASE 25 MG	1088	REBIF SUBCUTANEOUS*	1131
PROCYSBI ORAL CAPSULE DELAYED		REBIF TITRATION PACK SUBCUTANEOUS*	
RELEASE 75 MG	1089	.....	1134
PROFILNINE	1090	RECLAST	1135
PROFILNINE SD	1091	RECLIPSEN	1136
PROLASTIN-C INTRAVENOUS* SOLUTION		RECOMBINATE	1137
RECONSTITUTED 1000 MG	1092	RECTIV	1138
PROLIA	1093	RELENZA DISKHALER	1139
PROMACTA	1094	RELISTOR ORAL	1141
PROMACTA	1095	RELISTOR SUBCUTANEOUS* SOLUTION 12	
PROMETRIUM	1096	MG/0.6ML	1142
<i>propafenone hcl er</i>	1097	RELISTOR SUBCUTANEOUS* SOLUTION 8	
PROTOPIC	1098	MG/0.4ML	1140
PROVENTIL HFA	1100	REL PAX	1143
PROVIGIL	1101	REMERON	1144
PROZAC ORAL CAPSULE 10 MG	1103	REMERON SOLTAB	1145
PROZAC ORAL CAPSULE 20 MG	1104	REMICADE	1146
PROZAC ORAL CAPSULE 40 MG	1102	REMODULIN	1147
PROZAC WEEKLY	1105	<i>repaglinide-metformin hcl</i>	1148
PULMICORT	1106	REPATHA	1149
PULMICORT FLEXHALER	1107	REPATHA PUSHTRONEX SYSTEM	1150
PULMOZYME	1108	REPATHA SURECLICK	1151
PURIXAN	1109	REQUIP XL ORAL TABLET EXTENDED	
QBRELIS	1110	RELEASE 24 HR* 12 MG	1153
QNASL	1111	REQUIP XL ORAL TABLET EXTENDED	
QNASL CHILDRENS	1112	RELEASE 24 HR* 2 MG, 4 MG, 6 MG, 8 MG	
QUALAQUIN	1113	.....	1152
QUARTETTE	1114	RESCULA	1154
QUASENSE	1115	RESTORIL ORAL CAPSULE 22.5 MG, 7.5 MG	
QUDEXY XR ORAL 150 MG, 200 MG	1116	.....	1155
QUDEXY XR ORAL 25 MG, 100 MG, 50 MG		RETIN-A	1156
.....	1117	RETIN-A MICRO	1157
<i>quetiapine fumarate oral tablet 100 mg, 50 mg</i>		RETIN-A MICRO PUMP	1158
.....	1118	REVATIO INTRAVENOUS*	1159
<i>quetiapine fumarate oral tablet 200 mg</i>	1121	REVATIO ORAL SUSPENSION	
<i>quetiapine fumarate oral tablet 25 mg</i>	1119	RECONSTITUTED	1159
		REVATIO ORAL TABLET	1160

REVLIMID	1161	<i>ropinirole hcl er oral tablet extended release 24 hr* 12 mg</i>	1192
REXULTI	1162	<i>ropinirole hcl er oral tablet extended release 24 hr* 2 mg, 4 mg, 6 mg, 8 mg</i>	1193
REYATAZ ORAL CAPSULE 150 MG, 300 MG	1163	<i>rosuvastatin calcium</i>	1194
REYATAZ ORAL CAPSULE 200 MG	1164	ROZEREM	1195
RIASTAP	1165	RUCONEST	1196
RILUTEK	1166	RYTHMOL SR	1197
<i>riluzole</i>	1167	SABRIL	1198
<i>risedronate sodium oral tablet 150 mg</i>	1170	SABRIL	1199
<i>risedronate sodium oral tablet 35 mg</i>	1168	SAFYRAL	1200
<i>risedronate sodium oral tablet 5 mg, 30 mg</i>	1169	SAIZEN	1201
<i>risedronate sodium oral tablet delayed release</i>	1168	SAMSCA ORAL TABLET 15 MG	1202
RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 2 MG, 1 MG, 0.5 MG	1175	SAMSCA ORAL TABLET 30 MG	1203
RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 3 MG	1176	SANCUSO	1204
RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 4 MG	1177	SANDOSTATIN	1205
RISPERDAL ORAL SOLUTION	1172	SANDOSTATIN LAR DEPOT	1206
RISPERDAL ORAL TABLET 1 MG, 2 MG, 0.25 MG, 0.5 MG	1171	SAPHRIS	1207
RISPERDAL ORAL TABLET 3 MG	1174	SAVAYSA	1208
RISPERDAL ORAL TABLET 4 MG	1173	SAVELLA	1209
RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 1 MG, 2 MG, 0.5 MG	1181	SAVELLA TITRATION PACK	1210
RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 3 MG	1182	SAXENDA	1211
RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 4 MG	1183	SEASONIQUE	1212
<i>risperidone oral tablet 2 mg, 0.25 mg, 0.5 mg, 1 mg</i>	1179	SEEBRI NEOHALER	1213
<i>risperidone oral tablet 3 mg</i>	1180	SELZENTRY ORAL TABLET 150 MG	1214
<i>risperidone oral tablet 4 mg</i>	1178	SENSIPAR	1215
<i>risperidone oral tablet dispersible 1 mg, 2 mg, 0.5 mg</i>	1179	SEREVENT DISKUS	1216
<i>risperidone oral tablet dispersible 3 mg</i>	1180	SEROQUEL ORAL TABLET 200 MG	1221
<i>risperidone oral tablet dispersible 4 mg</i>	1178	SEROQUEL ORAL TABLET 25 MG	1220
RITALIN	1184	SEROQUEL ORAL TABLET 300 MG	1217
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 30 MG	1186	SEROQUEL ORAL TABLET 400 MG	1219
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 40 MG, 10 MG, 20 MG	1185	SEROQUEL ORAL TABLET 50 MG, 100 MG	1218
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 60 MG	1187	SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 200 MG	1222
<i>rivastigmine</i>	1188	SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 300 MG, 400 MG	1223
<i>rivastigmine tartrate</i>	1189	SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 50 MG	1224
RIXUBIS	1190	SEROSTIM SUBCUTANEOUS* SOLUTION RECONSTITUTED 6 MG, 5 MG, 4 MG	1225
<i>rizatriptan benzoate</i>	1191	<i>sertraline hcl oral concentrate</i>	1227
		<i>sertraline hcl oral tablet 100 mg</i>	1228
		<i>sertraline hcl oral tablet 25 mg</i>	1226
		<i>sertraline hcl oral tablet 50 mg</i>	1229
		SIGNIFOR	1230
		SIGNIFOR LAR	1231
		<i>sildenafil citrate oral</i>	1232
		SIMCOR	1233
		SIMPONI ARIA	1235
		SIMPONI SUBCUTANEOUS*	1234

<i>simvastatin oral</i>	1236	<i>sumatriptan succinate subcutaneous* 4 mg/0.5ml,</i>	
SINGULAIR.....	1237	<i>6 mg/0.5ml</i>	1281
SINGULAIR.....	1238	<i>sumatriptan succinate subcutaneous* solution 6</i>	
SIRTURO.....	1239	<i>mg/0.5ml</i>	1279
SIVEXTRO ORAL.....	1240	SUPARTZ INTRA-ARTICULAR*.....	1283
SKYLA.....	1241	SUPPRELIN LA.....	1284
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>		SUTENT.....	1285
.....	1242	SYEDA.....	1286
SOLIRIS.....	1243	SYLATRON SUBCUTANEOUS* KIT 200 MCG,	
SOMATULINE DEPOT.....	1244	300 MCG, 600 MCG.....	1287
SOMAVERT.....	1245	SYMBICORT.....	1288
SONATA.....	1246	SYMBYAX.....	1289
SOOLANTRA.....	1247	SYMLINPEN 120 SUBCUTANEOUS*.....	1290
SORIATANE ORAL CAPSULE 10 MG.....	1248	SYMLINPEN 60 SUBCUTANEOUS*.....	1291
SORIATANE ORAL CAPSULE 25 MG, 17.5 MG		SYNAGIS.....	1292
.....	1249	SYNAREL.....	1293
SOVALDI.....	1250	SYNJARDY.....	1294
SPIRIVA HANDIHALER.....	1251	SYNVISC INTRA-ARTICULAR*.....	1295
SPIRIVA RESPIMAT.....	1252	SYNVISC ONE INTRA-ARTICULAR*.....	1296
SPORANOX ORAL CAPSULE.....	1253	SYPRINE.....	1297
SPORANOX PULSEPAK.....	1254	TACLONEX EXTERNAL OINTMENT.....	1298
SPRINTEC 28.....	1255	<i>tacrolimus external</i>	1299
SPRITAM.....	1256	TAFINLAR.....	1301
SPRIX.....	1257	TAGRISSO.....	1302
SPRYCEL ORAL TABLET 100 MG, 140 MG		TAKE ACTION.....	1303
.....	1259	TALTZ.....	1304
SPRYCEL ORAL TABLET 70 MG, 80 MG, 20		TAMIFLU ORAL CAPSULE.....	1305
MG, 50 MG.....	1258	TAMIFLU ORAL SUSPENSION	
SRONYX.....	1260	RECONSTITUTED 6 MG/ML.....	1306
STELARA INTRAVENOUS*.....	1261	TANZEUM.....	1307
STELARA SUBCUTANEOUS*.....	1262	TARCEVA.....	1308
STIOLTO RESPIMAT.....	1263	TASIGNA.....	1309
STIVARGA.....	1264	TAYTULLA.....	1310
STRATTERA ORAL CAPSULE 100 MG, 80 MG		TAZORAC.....	1311
.....	1266	TAZTIA XT ORAL CAPSULE EXTENDED	
STRATTERA ORAL CAPSULE 25 MG, 40 MG,		RELEASE 24 HOUR 240 MG.....	1312
60 MG, 10 MG, 18 MG.....	1265	TAZTIA XT ORAL CAPSULE EXTENDED	
STRENSIQ.....	1267	RELEASE 24 HOUR 300 MG, 360 MG, 120 MG,	
STRIANT.....	1268	180 MG.....	1313
STRIBILD.....	1269	TECFIDERA.....	1314
STRIVERDI RESPIMAT.....	1270	TECHNIVIE.....	1315
SUBOXONE.....	1271	TEKTURNA.....	1316
SUBSYS.....	1273	TEKTURNA HCT.....	1317
SULAR ORAL TABLET EXTENDED RELEASE		<i>telmisartan</i>	1318
24 HR* 8.5 MG, 17 MG, 34 MG.....	1275	<i>telmisartan-amlodipine</i>	1319
<i>sulfasalazine oral</i>	1276	<i>telmisartan-hctz</i>	1320
SULFAZINE.....	1277	<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	1321
<i>sumatriptan nasal</i>	1278	TEMODAR ORAL.....	1322
<i>sumatriptan succinate oral</i>	1280	<i>temozolomide</i>	1323
<i>sumatriptan succinate refill subcutaneous*</i>	1282	TESTIM.....	1324
		<i>testosterone transdermal gel 10 mg/act (2%)</i> ...	1326

<i>testosterone transdermal gel 12.5 mg/act (1%)</i>	TREXIMET	1366
..... 1328	TRIBENZOR	1367
<i>testosterone transdermal gel 25 mg/2.5gm (1%)</i>	TRICOR	1368
..... 1325	TRI-ESTARYLLA	1369
<i>testosterone transdermal gel 50 mg/5gm (1%)</i>	TRIGLIDE ORAL TABLET 160 MG	1370
..... 1327	TRI-LEGEST FE	1371
<i>tetrabenazine oral tablet 12.5 mg</i>	TRI-LINYAH	1372
..... 1329	TRILIPIX	1373
<i>tetrabenazine oral tablet 25 mg</i>	TRINESSA (28)	1374
..... 1330	TRI-NORINYL (28)	1375
THALOMID	TRINTELLIX	1376
..... 1331	TRI-PREVIFEM	1377
THIOLA	TRI-SPRINTEC	1378
..... 1332	TRIUMEQ	1379
<i>tiagabine hcl oral tablet 2 mg</i>	TRIVORA (28)	1380
..... 1333	TROKENDI XR ORAL CAPSULE EXTENDED	
<i>tiagabine hcl oral tablet 4 mg</i>	RELEASE 24 HOUR 100 MG, 25 MG, 50 MG	1382
..... 1334	.....
TIAZAC ORAL CAPSULE EXTENDED	TROKENDI XR ORAL CAPSULE EXTENDED	
RELEASE 24 HOUR 240 MG	RELEASE 24 HOUR 200 MG	1381
..... 1336	<i>trospium chloride</i>	1383
TIAZAC ORAL CAPSULE EXTENDED	<i>trospium chloride er</i>	1384
RELEASE 24 HOUR 420 MG, 360 MG, 120 MG,	TRUETEST TEST	1385
300 MG, 180 MG	TRUETRACK TEST	1386
..... 1335	TRULICITY	1387
TILIA FE	TRUVADA	1388
..... 1337	TUDORZA PRESSAIR INHALATION	
TIVICAY	AEROSOL POWDER, BREATH ACTIVATED	
..... 1338	400 MCG/ACT	1389
TIVICAY	TUSSICAPS	1390
..... 1339	TWYNSTA	1391
TIVORBEX	TYBOST	1392
..... 1340	TYKERB	1393
TOBI	TYSABRI	1394
..... 1341	TYVASO	1395
TOBI PODHALER	TYVASO REFILL	1396
..... 1342	TYVASO STARTER	1397
<i>tobramycin inhalation</i>	TYZEKA	1398
..... 1343	UCERIS	1399
<i>tolterodine tartrate er</i>	UCERIS ORAL	1400
..... 1344	ULESFIA	1401
TOPAMAX SPRINKLE	ULORIC	1402
..... 1345	ULTRACET	1403
<i>topiramate oral capsule sprinkle</i>	UPTRAVI ORAL	1404
..... 1346	UPTRAVI ORAL TABLET 1600 MCG, 600	
TOPROL XL ORAL TABLET EXTENDED	MCG, 1000 MCG, 1200 MCG, 400 MCG, 1400	
RELEASE 24 HR* 100 MG, 50 MG	MCG, 800 MCG	1405
..... 1347	UPTRAVI ORAL TABLET 200 MCG	1404
TOPROL XL ORAL TABLET EXTENDED	UROXATRAL	1406
RELEASE 24 HR* 200 MG	VALCHLOR	1407
..... 1348		
TOPROL XL ORAL TABLET EXTENDED		
RELEASE 24 HR* 25 MG		
..... 1349		
TOUJEO SOLOSTAR		
..... 1350		
TOVIAZ		
..... 1351		
TRACLEER		
..... 1352		
TRADJENTA		
..... 1353		
<i>tramadol hcl er oral capsule extended release 24</i>		
<i>hour 300 mg, 100 mg, 200 mg</i>		
..... 1354		
<i>tramadol-acetaminophen</i>		
..... 1355		
<i>tranexamic acid oral</i>		
..... 1356		
<i>travoprost</i>		
..... 1357		
TRELSTAR		
..... 1358		
TRELSTAR MIXJECT		
..... 1359		
<i>tretinoin external</i>		
..... 1360		
<i>tretinoin microsphere</i>		
..... 1361		
<i>tretinoin microsphere pump</i>		
..... 1362		
TRETIN-X EXTERNAL CREAM 0.0375 %		
..... 1363		
TRETIN-X EXTERNAL CREAM 0.075 %		
..... 1364		
TRETTEN		
..... 1365		

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)

VALCYTE ORAL SOLUTION RECONSTITUTED	1408	VIIBRYD ORAL TABLET	1449
VALCYTE ORAL TABLET	1409	VIMIZIM	1450
<i>valganciclovir hcl oral solution reconstituted</i>	1410	VIMPAT ORAL SOLUTION	1451
<i>valganciclovir hcl oral tablet</i>	1411	VIMPAT ORAL TABLET	1452
<i>valsartan</i>	1412	VIOKACE	1453
<i>valsartan-hydrochlorothiazide</i>	1413	VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR* 100 MG	1455
VANOS	1414	VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR* 400 MG	1454
VANTAS	1415	VIREAD ORAL TABLET	1456
VARUBI	1416	VISTOGARD	1457
VASCEPA ORAL CAPSULE 1 GM	1417	VISUDYNE	1458
VECAMYL	1418	VITUZ	1459
VELETRI	1419	VIVELLE-DOT	1460
VELIVET	1420	VIVLODEX	1461
VELTASSA	1421	VOGELXO PUMP	1463
VELTIN	1422	VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%)	1462
VENCLEXTA ORAL TABLET 10 MG	1425	VOLTAREN TRANSDERMAL	1464
VENCLEXTA ORAL TABLET 100 MG	1424	VONVENDI	1465
VENCLEXTA ORAL TABLET 50 MG	1423	VOTRIENT	1466
VENCLEXTA STARTING PACK	1426	VPRIV	1467
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg</i>	1433	VRAYLAR ORAL	1470
<i>venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg</i>	1434	VRAYLAR ORAL CAPSULE 1.5 MG	1469
<i>venlafaxine hcl er oral tablet extended release 24 hr* 150 mg</i>	1431	VRAYLAR ORAL CAPSULE 3 MG	1471
<i>venlafaxine hcl er oral tablet extended release 24 hr* 75 mg, 225 mg, 37.5 mg</i>	1432	VRAYLAR ORAL CAPSULE 6 MG, 4.5 MG	1468
<i>venlafaxine hcl oral tablet 100 mg, 25 mg</i>	1428	VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG	1472
<i>venlafaxine hcl oral tablet 37.5 mg</i>	1427	VYTORIN ORAL TABLET 10-80 MG	1473
<i>venlafaxine hcl oral tablet 50 mg</i>	1429	VYVANSE	1474
<i>venlafaxine hcl oral tablet 75 mg</i>	1430	WELLBUTRIN ORAL TABLET 100 MG	1475
VENTAVIS	1435	WELLBUTRIN SR	1476
VERAMYST	1436	WELLBUTRIN XL	1477
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg</i>	1438	WERA	1478
<i>verapamil hcl er oral capsule extended release 24 hour 200 mg</i>	1437	WILATE INTRAVENOUS* KIT	1479
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG	1440	WILATE INTRAVENOUS* SOLUTION RECONSTITUTED 1000-1000 UNIT, 500-500 UNIT	1479
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 100 MG	1439	WYMZYA FE	1480
VERSACLOZ	1441	XALATAN	1481
VESICARE	1442	XALKORI	1482
VESTURA	1443	XANAX XR	1483
VIBERZI	1444	XARTEMIS XR	1484
VICTOZA SUBCUTANEOUS*	1445	XELJANZ	1485
VIEKIRA PAK	1446	XELJANZ XR	1486
VIEKIRA XR	1447	XELODA	1487
VIIBRYD ORAL TABLET	1448	XENAZINE ORAL TABLET 12.5 MG	1488
		XENAZINE ORAL TABLET 25 MG	1489
		XEOMIN	1490
		XGEVA	1491

XIFAXAN ORAL TABLET 200 MG	1492	ZOFRAN ORAL TABLET	1535
XIFAXAN ORAL TABLET 550 MG	1493	ZOHYDRO ER ORAL	1537
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HR* 5-1000 MG	1495	ZOLADEX	1538
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HR* 5-500 MG, 10-1000 MG, 10-500 MG	1494	<i>zoledronic acid</i>	1539
XOLAIR	1496	ZOLINZA	1540
XOPENEX HFA	1497	<i>zolmitriptan oral tablet 2.5 mg</i>	1541
XTAMPZA ER	1498	<i>zolmitriptan oral tablet 5 mg</i>	1543
XTANDI	1499	<i>zolmitriptan oral tablet dispersible 2.5 mg</i>	1542
XULANE	1500	<i>zolmitriptan oral tablet dispersible 5 mg</i>	1543
XURIDEN	1501	ZOLOFT ORAL CONCENTRATE	1545
XYNTHA INTRAVENOUS* KIT 1000 UNIT, 2000 UNIT, 500 UNIT, 250 UNIT	1502	ZOLOFT ORAL TABLET 100 MG	1544
XYNTHA SOLOFUSE	1503	ZOLOFT ORAL TABLET 25 MG	1547
XYREM	1504	ZOLOFT ORAL TABLET 50 MG	1546
XYZAL	1505	<i>zolpidem tartrate er</i>	1549
XYZAL	1506	<i>zolpidem tartrate oral</i>	1548
YASMIN 28	1507	ZOMACTON	1550
YAZ	1508	ZOMETA	1551
ZARAH	1509	ZOMIG	1552
ZARXIO	1510	ZOMIG	1553
ZAVESCA	1511	ZOMIG ZMT	1554
ZECUITY	1512	ZONTIVITY	1555
ZEGERID ORAL CAPSULE	1513	ZORBITIVE	1556
ZEGERID ORAL PACKET	1514	ZORVOLEX	1557
ZEGERID OTC	1515	ZOVIA 1/35E (28)	1558
ZELAPAR	1516	ZOVIA 1/50E (28)	1559
ZELBORAF	1517	ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG	1560
ZEMAIRA	1518	ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG	1564
ZEMBRACE SYMTOUCH	1519	ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG	1566
ZEMPLAR ORAL CAPSULE 2 MCG, 1 MCG	1520	ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG	1562
<i>zenatane oral capsule 20 mg, 10 mg, 40 mg</i>	1521	ZURAMPIC	1568
ZENATANE ORAL CAPSULE 30 MG	1521	ZYDELIG	1569
ZENCHENT	1522	ZYKADIA	1570
ZENCHENT FE	1523	ZYPREXA ORAL	1571
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 7.5 MG, 30 MG	1524	ZYPREXA ZYDIS	1572
ZENZEDI ORAL TABLET 5 MG, 10 MG	1525	ZYTIGA	1573
ZEPATIER	1526	ZYVOX ORAL SUSPENSION RECONSTITUTED	1575
ZETIA	1527	ZYVOX ORAL TABLET	1574
ZETONNA	1528		
ZIANA	1529		
ZINBRYTA	1530		
ZIOPTAN	1531		
<i>ziprasidone hcl</i>	1532		
ZOCOR	1533		
ZOFRAN ODT	1536		
ZOFRAN ORAL SOLUTION	1534		

2016 Aetna Pharmacy Drug Guide - Value Plus Formulary
(Updated 12/2016)