Acamprosate Calcium

Products Affected

- *acamprosate calcium*

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

Accu-Chek Aviva Plus

Products Affected

- ACCU-CHEK AVIVA PLUS IN VITRO

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

Accu-Chek Compact Plus

Products Affected

- ACCU-CHEK COMPACT PLUS

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

Accu-Chek SmartView

Products Affected

- ACCU-CHEK SMARTVIEW

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

Accu-Chek Softclix Lancet Dev

Products Affected

- ACCU-CHEK SOFTCLIX LANCET DEV KIT

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

Accutrend Glucose

Products Affected

- ACCUTREND GLUCOSE

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

Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acetaminophen-Codeine #2

Products Affected

- *acetaminophen-codeine #2*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acetaminophen-Codeine #3

Products Affected

- *acetaminophen-codeine #3*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acetaminophen-Codeine #4

Products Affected

- *acetaminophen-codeine #4*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acitretin

Products Affected

- *acitretin*

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

Acitretin

Products Affected

- *acitretin*

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

Actemra

Products Affected

- ACTEMRA INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Actemra.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actemra

Products Affected

- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Actemra.html
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

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/2017/MISC/actimmune.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actoplus met XR

Products Affected

- ACTOPLUS MET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 15-1000 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of metformin 1500mg/day
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 ORAL TABLET EXTENDED RELEASE 24 HOUR 30-1000 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of metformin 1500mg/day
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

Adapalene

Products Affected

- *adapalene external lotion*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin
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/2017/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/2017/CV/pulmonaryhypertensionagents.html
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Addyi

Products Affected

- ADDYI

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

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

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/2017/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/2017/CV/pulmonaryhypertensionagents.html
QL Criteria	3 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: December 22, 2016 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, 250-50 MCG/DOSE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Dulera
QL Criteria	1 diskus 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

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

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

Advance Intuition Test

Products Affected

- ADVANCE INTUITION TEST

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

Advocate Duo

Products Affected

- ADVOCATE DUO DEVICE

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

Advocate Redi-Code

Products Affected

- ADVOCATE REDI-CODE IN VITRO

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

Advocate Redi-Code+ Test

Products Affected

- ADVOCATE REDI-CODE+ TEST

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

Advocate Test

Products Affected

- ADVOCATE TEST

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

Afeditab CR

Products Affected

- AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG

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

Afeditab CR

Products Affected

- AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG

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

Afinitor

Products Affected

- AFINITOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix AMP Test

Products Affected

- AGAMATRIX AMP TEST

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

AgaMatrix Jazz Test

Products Affected

- AGAMATRIX JAZZ TEST

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

AgaMatrix KeyNote Test

Products Affected

- AGAMATRIX KEYNOTE TEST

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

AgaMatrix Presto Test

Products Affected

- AGAMATRIX PRESTO TEST

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

Akynzeo

Products Affected

- AKYNZEO

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of nausea and vomiting associated with cancer chemotherapy
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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of aprepitant and either ondansetron or granisetron
QL Criteria	2 capsules Per 1 month
Notes/ References	Annual Review: 03/2017
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/2017/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: January 11, 2017 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

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 tablet 40 mg, 5 mg*

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

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

Alimta

Products Affected

- ALIMTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Alimta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Almotriptan Malate

Products Affected

- *almotriptan malate*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 tablets Per 30 Days
Notes/ References	
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	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alogliptin-Metformin HCl

Products Affected

- *alogliptin-metformin hcl*

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

Alogliptin-Pioglitazone

Products Affected

- *alogliptin-pioglitazone*

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

Alosetron HCl

Products Affected

- *alosetron hcl*

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

Aloxi

Products Affected

- ALOXI INTRAVENOUS SOLUTION 0.25 MG/5ML

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

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

Altoprev

Products Affected

- ALTOPREV

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastain
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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amitiza

Products Affected

- AMITIZA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of lactulose or polyethylene glycol
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*

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

Amlodipine-Olmesartan

Products Affected

- *amlodipine-olmesartan*

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

Amlodipine-Valsartan-HCTZ

Products Affected

- *amlodipine-valsartan-hctz*

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

Amnesteem

Products Affected

- AMNESTEEM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 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/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Anoro Ellipta

Products Affected

- ANORO ELLIPTA

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

Anzemet

Products Affected

- ANZEMET ORAL

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

APAP-Caff-Dihydrocodeine

Products Affected

- *apap-caff-dihydrocodeine oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apidra

Products Affected

- APIDRA

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

Apidra SoloStar

Products Affected

- APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

Aprepitant

Products Affected

- *aprepitant oral capsule 40 mg, 80 mg*

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

Aprepitant

Products Affected

- *aprepitant oral capsule 80 & 125 mg*

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

Apriso

Products Affected

- APRISO

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

Aptiom

Products Affected

- APTIOM ORAL TABLET 200 MG

QL Criteria	6 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aralast NP

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aranesp (Albumin Free)

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arcapta Neohaler

Products Affected

- ARCAPTA NEOHALER

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

ARIPiprazole

Products Affected

- *aripiprazole oral solution*

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

ARIPiprazole

Products Affected

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

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

Armodafinil

Products Affected

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

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

ST Criteria	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: A documented contraindication, intolerance, allergy, or failure of an adequate trial of at least two immediate release stimulants and modafinil (modafinil requires prior authorization). FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: A documented contraindication, intolerance, allergy, or failure of an adequate trial of modafinil (modafinil requires prior authorization).
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 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 patient's ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

ST Criteria	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: A documented contraindication, intolerance, allergy, or failure of an adequate trial of at least two immediate release stimulants and modafinil (modafinil requires prior authorization). FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: A documented contraindication, intolerance, allergy, or failure of an adequate trial of modafinil (modafinil requires prior authorization).
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arzerra

Products Affected

- ARZERRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Arzerra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ascomp-Codeine

Products Affected

- ASCOMP-CODEINE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asmanex 120 Metered Doses

Products Affected

- ASMANEX 120 METERED DOSES

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

Asmanex 14 Metered Doses

Products Affected

- ASMANEX 14 METERED DOSES

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

Asmanex 30 Metered Doses

Products Affected

- ASMANEX 30 METERED DOSES

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

Asmanex 60 Metered Doses

Products Affected

- ASMANEX 60 METERED DOSES

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

Asmanex HFA

Products Affected

- ASMANEX HFA

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

Assure 3 Test

Products Affected

- ASSURE 3 TEST

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

Assure 4 Test

Products Affected

- ASSURE 4 TEST

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

Assure Platinum

Products Affected

- ASSURE PLATINUM

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

Assure Pro Test

Products Affected

- ASSURE PRO TEST

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

Atomoxetine HCl

Products Affected

- *atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a stimulant
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atomoxetine HCl

Products Affected

- *atomoxetine hcl oral capsule 100 mg, 80 mg*

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

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

QL Criteria	1 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

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/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avandia

Products Affected

- AVANDIA ORAL TABLET 2 MG, 4 MG

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

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/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	1 kit Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avonex Pen

Products Affected

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	4 pens Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avonex Prefilled

Products Affected

- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	4 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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

Banzel

Products Affected

- BANZEL ORAL TABLET

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

Bayer Breeze 2 Test

Products Affected

- BAYER BREEZE 2 TEST

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

Bayer Contour Test

Products Affected

- BAYER CONTOUR TEST

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

Beconase AQ

Products Affected

- BECONASE AQ

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

Belsomra

Products Affected

- BELSOMRA

PA Criteria	Criteria Details
Covered Uses	Insomnia
Exclusion Criteria	
Required Medical Information	A diagnosis of insomnia
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Belviq

Products Affected

- BELVIQ

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30kg/m2 or BMI greater than 27kg/m2 with one or more of the items in the required medical information section
Exclusion Criteria	Concomitant use of two or more anti-obesity agents, pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140mm Hg or diastolic blood pressure greater than 90mm Hg on more than one occasion), Dyslipidemia (LDL cholesterol greater than/= 160mg/dL: HDL cholesterol less than 35mg/dL: triglycerides greater than/= 400mg/dL), Type 2 Diabetes Mellitus, Coronary Heart Disease, or Obstructive Sleep Apnea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of phentermine cap or phendimetrazine tab
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benlysta

Products Affected

- BENLYSTA INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/benlysta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/benlysta.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/benlysta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/benlysta.html
QL Criteria	4 injections Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/hereditary_angioedema.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	15 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bexarotene

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Targretin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: 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	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bosulif

Products Affected

- BOSULIF ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/ANEOPL/Antineoplastics.html
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bosulif

Products Affected

- BOSULIF ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/ANEOPL/Antineoplastics.html
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/botulinum_toxin.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bravelle

Products Affected

- BRAVELLE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Breo Ellipta

Products Affected

- BREO ELLIPTA

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

Brilinta

Products Affected

- BRILINTA

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

Brilinta

Products Affected

- BRILINTA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of clopidogrel
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Brovana

Products Affected

- BROVANA

QL Criteria	60 vials Per 1 fill
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 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	1 year
Other Criteria	No prior authorization required for children 1-4 years of age. Medical Exception allowed for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory and for Nasal Polyps when all criteria met: A diagnosis of chronic sinusitis with nasal polyposis, endoscopic sinus surgery has been performed, and standard nasal steroid sprays have been used as part of post-operative management and have failed.
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: July 25, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	6 films Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 4.2-0.7 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 films Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 6.3-1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	2 films Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buphenyl

Products Affected

- BUPHENYL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine

Products Affected

- *buprenorphine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	4 patches Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual*

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

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl*

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

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

QL Criteria	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

Butalbital-APAP-Caff-Cod

Products Affected

- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Butalbital-ASA-Caff-Codeine

Products Affected

- *butalbital-asa-caff-codeine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Butorphanol Tartrate

Products Affected

- *butorphanol tartrate nasal*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	2 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bydureon

Products Affected

- BYDUREON SUBCUTANEOUS PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must have an A1C level is greater than 6.5%,
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Byetta 10 MCG Pen

Products Affected

- BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must have an A1C level is greater than 6.5%,
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	1 pen Per 1 fill
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Byetta 5 MCG Pen

Products Affected

- BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must have an A1C level is greater than 6.5%,
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	1 pen Per 1 fill
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bystolic

Products Affected

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

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

Bystolic

Products Affected

- BYSTOLIC ORAL TABLET 20 MG

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

Calcipotriene

Products Affected

- *calcipotriene external*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 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	A documented contraindication, intolerance, allergy, or failure of calcipotriene and 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

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

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

Calcitrene

Products Affected

- CALCITRENE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a medium to high potency topical steroid
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Canasa

Products Affected

- CANASA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Apriso
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 oral tablet 16 mg, 4 mg, 8 mg*

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

Candesartan Cilexetil-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/2017/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: September 21, 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/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/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: September 21, 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/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cardura XL

Products Affected

- CARDURA XL

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

CareSens N Glucose Test

Products Affected

- CARESENS N GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
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 120 MG, 300 MG
- CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 180 MG

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

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

Cayston

Products Affected

- CAYSTON

QL Criteria	3 vials 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*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two non steroidal anti-inflammatory drugs (NSAID)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cerezyme

Products Affected

- CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: January 11, 2017 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

Cetrotide

Products Affected

- CETROTIDE SUBCUTANEOUS KIT 0.25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cevimeline HCl

Products Affected

- *cevimeline hcl*

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

Chantix

Products Affected

- CHANTIX

QL Criteria	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

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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Leap Pharmacy Drug Guide
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Chorionic Gonadotropin

Products Affected

- *chorionic gonadotropin intramuscular*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cialis

Products Affected

- CIALIS ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	Benign Prostatic hyperplasia (BPH)
Exclusion Criteria	Use solely for erectile dysfunction.
Required Medical Information	Diagnosis of benign prostatic hyperplasia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two alpha blockers and one 5-alpha reductase inhibitor
QL Criteria	1 tablets Per 1 Day
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciclodan

Products Affected

- CICLODAN EXTERNAL SOLUTION

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

Ciclopirox

Products Affected

- *ciclopirox external solution*

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

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/2017/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/2017/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2017/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/2017/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2017/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/2017/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 year
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

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

Claravis

Products Affected

- CLARAVIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code

Products Affected

- CLEVER CHEK AUTO-CODE

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

Clever Chek Auto-Code Test

Products Affected

- CLEVER CHEK AUTO-CODE TEST

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

Clever Chek Auto-Code Voice

Products Affected

- CLEVER CHEK AUTO-CODE VOICE IN VITRO

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

Clever Chek Test

Products Affected

- CLEVER CHEK TEST

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

Clever Choice Auto-Code Test

Products Affected

- CLEVER CHOICE AUTO-CODE TEST

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

Clever Choice Micro Test

Products Affected

- CLEVER CHOICE MICRO TEST

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a stimulant
QL Criteria	4 tabs Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate oral*

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

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate oral*

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 200 mg*

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

Codeine Sulfate

Products Affected

- *codeine sulfate oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Colchicine

Products Affected

- *colchicine oral tablet*

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

CombiPatch

Products Affected

- COMBIPATCH

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

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/2017/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: September 21, 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/2017/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: September 21, 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/2017/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 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Complera

Products Affected

- COMPLERA

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

Contrave

Products Affected

- CONTRAVE

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30kg/m2 or BMI greater than 27kg/m2 with one or more of the items in the required medical information section
Exclusion Criteria	Concomitant use of two or more anti-obesity agents, pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140mm Hg or diastolic blood pressure greater than 90mm Hg on more than one occasion), Dyslipidemia (LDL cholesterol greater than/= 160mg/dL: HDL cholesterol less than 35mg/dL: triglycerides greater than/= 400mg/dL), Type 2 Diabetes Mellitus, Coronary Heart Disease, or Obstructive Sleep Apnea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of phentermine cap or phendimetrazine tab
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Copaxone

Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 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

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

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, nevibolol) or have a documented contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of a formualry ACE Inhibitor, ACE Inhibitor/HCTZ combination product, Angiotensin-Receptor Blocker, or Angiotensin-Receptor Blocker/HCTZ combination product
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cosopt PF

Products Affected

- COSOPT PF

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

Creon

Products Affected

- CREON

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

Crinone

Products Affected

- CRINONE VAGINAL GEL 4 %

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

Crinone

Products Affected

- CRINONE VAGINAL GEL 8 %

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Not covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Covered for prevention of early pregnancy failure, for ART (Assisted Reproductive Technology) when there is a documented diagnosis of progesterone deficiency in an infertile woman who has infertility coverage, and for secondary amenorrhea when there is a documented diagnosis of progesterone deficiency in an infertile woman who has infertility coverage
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Crinone 4%
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cuvposa

Products Affected

- CUVPOSA

PA Criteria	Criteria Details
Covered Uses	neurologic conditions associated with drooling (e.g. cerebral palsy)
Exclusion Criteria	
Required Medical Information	Documentaion of neurologic conditions associated with drooling (e.g. cerebral palsy) to reduce severe chronic drooling
Age Restrictions	3 years to 16 years
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 02/2017
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

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/2017/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: January 11, 2017 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/2017/EYE/ophthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 bottles Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dacogen

Products Affected

- DACOGEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daklinza

Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/GI/hepatitis_c.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daliresp

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	Severe COPD
Exclusion Criteria	Use for relief of acute bronchospasm
Required Medical Information	A diagnosis of severe COPD (FEV1 less than 50% predicted) associated with chronic bronchitis and at least one documented COPD exacerbation in the previous year
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Incruse and either Advair, Symbicort, or Serevent
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Darifenacin Hydrobromide ER

Products Affected

- *darifenacin hydrobromide er*

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

Daytrana

Products Affected

- DAYTRANA

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	1 patch Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Decitabine

Products Affected

- *decitabine*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Delzicol

Products Affected

- DELZICOL

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

Denavir

Products Affected

- DENAVIR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oral acyclovir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desloratadine

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Claritin OTC, Zyrtec OTC, Allegra OTC
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desloratadine

Products Affected

- *desloratadine oral tablet dispersible 5 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Claritin OTC, Zyrtec OTC, Allegra OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desvenlafaxine Succinate ER

Products Affected

- *desvenlafaxine succinate er*

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD)
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: April 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexilant

Products Affected

- DEXILANT

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	A diagnosis of Zollinger-Ellison syndrome, uncomplicated gastroesophageal reflux desease (GERD) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, short term court of high dose= 3 months
Other Criteria	
ST Criteria	ONCE DAILY DOSING OF RABEPRAZOLE (20mg), DEXILANT (60mg), AND NEXIUM (40mg): A documented contraindication, intolerance, allergy, or failure of Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. HIGH DOSE NEXIUM (80mg) OR HIGH DOSE RABEPRAZOLE (40mg): A documented contraindication, intolerance, allergy, or failure of 80mg/day of Prilosec OTC/omeprazole or pantoprazole or though 60mg/day of Prevacid 24H OTC.
QL Criteria	1 capsule Per 1 Day

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Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	40 ML Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

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

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

DiazePAM

Products Affected

- *diazepam rectal*

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

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 1 %*

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

Dificid

Products Affected

- DIFICID

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

Diltiazem CD

Products Affected

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

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

Diltiazem CD

Products Affected

- *diltiazem cd oral capsule extended release 24 hour 240 mg*

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

Diltiazem 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, 180 mg, 300 mg, 360 mg*

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Coated Beads

Products Affected

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

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

DilTIAZem HCl ER Coated Beads

Products Affected

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

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

DilTIAZem HCl ER Coated Beads

Products Affected

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

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

Dilt-XR

Products Affected

- *dilt-xr oral capsule extended release 24 hour 240 mg*

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

Dipentum

Products Affected

- DIPENTUM

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

Divigel

Products Affected

- DIVIGEL

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

Donepezil HCl

Products Affected

- *donepezil hcl oral tablet 23 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of donepezil 10mg
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	Multiple sclerosis (spasticity), Fibromyalgia (Neuropathic Pain)
Required Medical Information	A diagnosis of anorexia associated with weight loss in patients with AIDS or for the treatment of chemotherapy induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 12 months if demonstrated adequate response to therapy.
Other Criteria	
ST Criteria	FOR CHEMOTHERAPY INDUCED NAUSEA AND VOMITING ONLY: A documented contraindication, intolerance, allergy, or failure of prochlorperazine, chlorpromazine, haloperidol or metoclopramide
QL Criteria	2 caps Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Duavee

Products Affected

- DUAVEE

PA Criteria	Criteria Details
Covered Uses	Treatment of moderate to severe vasomotor symptoms associated with menopause, Prevention of postmenopausal osteoporosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause or prevention of postmenopausal osteoporosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of estrogen products and raloxifene
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 12, 2016 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 20 mg*

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

DULoxetine HCl

Products Affected

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

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

DULoxetine HCl

Products Affected

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

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

Dutasteride

Products Affected

- *dutasteride*

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

Easy Plus II Glucose Test

Products Affected

- *easy plus ii glucose test*

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

Easy Step Test

Products Affected

- EASY STEP TEST

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

Easy Talk Blood Glucose Test

Products Affected

- *easy talk blood glucose test*

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

Easy Touch Test

Products Affected

- EASY TOUCH TEST

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

Easy Trak Blood Glucose Test

Products Affected

- *easy trak blood glucose test*

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

EasyGluco

Products Affected

- EASYGLUCO IN VITRO

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

EasyMax 15 Test

Products Affected

- EASYMAX 15 TEST

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

EASYMax Test

Products Affected

- EASYMAX TEST

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

EasyPlus Blood Glucose Test

Products Affected

- *easyplus blood glucose test*

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

EasyPRO Plus

Products Affected

- EASYPRO PLUS IN VITRO

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

Edarbi

Products Affected

- EDARBI

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

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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2017/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: January 11, 2017 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/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html
Notes/ References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Element Test

Products Affected

- ELEMENT TEST

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

Eletriptan Hydrobromide

Products Affected

- *eletriptan hydrobromide*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 tablets Per 30 Days
Notes/ References	
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	atopic dermatitis
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (3 months if less than 2 years old)
Other Criteria	
ST Criteria	FOR ADULTS: A documented contraindication, intolerance, allergy, or failure of a 2 week trial (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition (Step therapy not required if in an area at high risk area such as face, eyelids, or genital areas)
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eliquis

Products Affected

- ELIQUIS

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

Embeda

Products Affected

- EMBEDA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

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

Embrace Blood Glucose Test

Products Affected

- EMBRACE BLOOD GLUCOSE TEST

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

Emsam

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD)
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 patch Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emtriva

Products Affected

- EMTRIVA ORAL CAPSULE

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

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
QL Criteria	8 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
QL Criteria	4 syringes Per 28 Days
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 SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
QL Criteria	4 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Endocet

Products Affected

- ENDOCET ORAL TABLET 10-325 MG, 5-325 MG
- ENDOCET ORAL TABLET 2.5-325 MG, 7.5-325 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Endometrin

Products Affected

- ENDOMETRIN

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

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

Epclusa

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Epiduo Forte

Products Affected

- EPIDUO FORTE

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

EPINEPHrine

Products Affected

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

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

EPINEPHrine

Products Affected

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

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

EpiPen 2-Pak

Products Affected

- EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR

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 SOLUTION AUTO-INJECTOR

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 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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: December 22, 2016 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/2017/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 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

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

Escitalopram Oxalate

Products Affected

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

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

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	A diagnosis of Zollinger-Ellison syndrome, uncomplicated gastroesophageal reflux desease (GERD) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, short term court of high dose= 3 months
Other Criteria	
ST Criteria	ONCE DAILY DOSING OF RABEPRAZOLE (20mg), DEXILANT (60mg), AND NEXIUM (40mg): A documented contraindication, intolerance, allergy, or failure of Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. HIGH DOSE NEXIUM (80mg) OR HIGH DOSE RABEPRAZOLE (40mg): A documented contraindication, intolerance, allergy, or failure of 80mg/day of Prilosec OTC/omeprazole or pantoprazole or though 60mg/day of Prevacid 24H OTC.
QL Criteria	1 capsule Per 1 Day

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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 twice weekly*

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

Estradiol

Products Affected

- *estradiol transdermal patch weekly*

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

Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

QL Criteria	1 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

Eszopiclone

Products Affected

- *eszopiclone*

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

Evamist

Products Affected

- EVAMIST

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

EvenCare + Blood Glucose Test

Products Affected

- EVENCARE + BLOOD GLUCOSE TEST

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

EvenCare Blood Glucose Test

Products Affected

- EVENCARE BLOOD GLUCOSE TEST

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

EvenCare G2 Test

Products Affected

- EVENCARE G2 TEST

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

EvenCare G3 Test

Products Affected

- EVENCARE G3 TEST

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

Evolution Autocode

Products Affected

- EVOLUTION AUTOCODE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
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/2017/MISC/Anitdotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	15 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Blood Glucose Test

Products Affected

- EZ SMART BLOOD GLUCOSE TEST

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

Ez Smart Plus Glucose Test

Products Affected

- EZ SMART PLUS GLUCOSE TEST

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

Ezetimibe

Products Affected

- *ezetimibe*

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

Ezetimibe-Simvastatin

Products Affected

- *ezetimibe-simvastatin*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastain
QL Criteria	1 tablet Per 1 Day
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/2017/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: January 11, 2017 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

Fanapt

Products Affected

- FANAPT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
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 contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
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

Felodipine ER

Products Affected

- *felodipine er*

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

Femring

Products Affected

- FEMRING

QL Criteria	1 ring Per 90 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 06, 2017

Fenofibrate

Products Affected

- *fenofibrate 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

Fenofibrate

Products Affected

- *fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg*

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

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

Fenofibric Acid

Products Affected

- *fenofibric acid oral tablet*

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

FentaNYL

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	20 patches Per 30 Days
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FentaNYL Citrate

Products Affected

- *fentanyl citrate buccal*

PA Criteria	Criteria Details
Covered Uses	Pain due to malignant diagnosis only
Exclusion Criteria	Non-malignant pain, management of acute or postoperative or in patients not taking chronic opiates or not tolerant to opioid therapy.
Required Medical Information	Covered for members with pain due to malignant diagnosis only
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone.
QL Criteria	120 lozenges Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 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/2017/MISC/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fetzima

Products Affected

- FETZIMA

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD)
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 cap Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: April 20, 2017 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 (MDD)
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: April 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fifty50 Glucose Test 2.0

Products Affected

- FIFTY50 GLUCOSE TEST 2.0

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

Firmagon

Products Affected

- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

First-Progesterone VGS 100

Products Affected

- FIRST-PROGESTERONE VGS 100

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

First-Progesterone VGS 200

Products Affected

- FIRST-PROGESTERONE VGS 200

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

Flebogamma DIF

Products Affected

- FLEBOGAMMA DIF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flovent Diskus

Products Affected

- FLOVENT DISKUS

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

Flovent HFA

Products Affected

- FLOVENT HFA

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

Flowtuss

Products Affected

- FLOWTUSS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a codeine/guaifenesin combination product
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 capsule 40 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

Fluticasone Propionate

Products Affected

- *fluticasone propionate nasal*

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

Fluticasone-Salmeterol

Products Affected

- *fluticasone-salmeterol*

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

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

Fluvastatin Sodium ER

Products Affected

- *fluvastatin sodium er*

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

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

FluvoxaMINE Maleate

Products Affected

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

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

Follistim AQ

Products Affected

- FOLLISTIM AQ INJECTION SOLUTION 75 UNT/0.5ML
- FOLLISTIM AQ SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium*

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

FORA D10 2-in-1 Monitor

Products Affected

- FORA D10 2-IN-1 MONITOR

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

FORA D15g 2-in-1 Monitor

Products Affected

- FORA D15G 2-IN-1 MONITOR

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

FORA D15g Blood Glucose Test

Products Affected

- FORA D15G BLOOD GLUCOSE TEST

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

FORA D20 2-in-1 Monitor

Products Affected

- FORA D20 2-IN-1 MONITOR

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

FORA D20 Blood Glucose Test

Products Affected

- FORA D20 BLOOD GLUCOSE TEST

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

FORA G20 Blood Glucose Test

Products Affected

- FORA G20 BLOOD GLUCOSE TEST

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

FORA G30a Blood Glucose Test

Products Affected

- FORA G30A BLOOD GLUCOSE TEST

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

Fora GD20 Test

Products Affected

- FORA GD20 TEST

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

FORA V10 Blood Glucose Test

Products Affected

- FORA V10 BLOOD GLUCOSE TEST

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

FORA V12 Blood Glucose Test

Products Affected

- FORA V12 BLOOD GLUCOSE TEST

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

FORA V20 Blood Glucose Test

Products Affected

- FORA V20 BLOOD GLUCOSE TEST

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

FORA V30a Blood Glucose Test

Products Affected

- FORA V30A BLOOD GLUCOSE TEST

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

ForaCare GD40 Test

Products Affected

- FORACARE GD40 TEST

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

ForaCare premium V10 Test

Products Affected

- FORACARE PREMIUM V10 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
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/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fosamax Plus D

Products Affected

- FOSAMAX PLUS D

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

Fragmin

Products Affected

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

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

FreeStyle InsuLinx Test

Products Affected

- FREESTYLE INSULINX TEST

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

FreeStyle Lite Test

Products Affected

- FREESTYLE LITE TEST

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

FreeStyle Test

Products Affected

- FREESTYLE TEST

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

Frovatriptan Succinate

Products Affected

- *frovatriptan succinate*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	9 tablets Per 30 Days
Notes/ References	
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: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gabapentin

Products Affected

- *gabapentin oral solution 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

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

Gammaplex

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gamunex-C

Products Affected

- GAMUNEX-C

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ganirelix Acetate

Products Affected

- *ganirelix acetate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/MISC/Gattex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 30 fillss
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GE100 Blood Glucose Test

Products Affected

- *ge100 blood glucose test*

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

Gelnique

Products Affected

- GELNIQUE TRANSDERMAL GEL 10 %

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

Genvoya

Products Affected

- GENVOYA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Giazo

Products Affected

- GIAZO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of balsalazide
QL Criteria	6 tabs Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/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 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/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: September 21, 2016 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GlucaGen Diagnostic

Products Affected

- GLUCAGEN DIAGNOSTIC

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

GlucaGen HypoKit

Products Affected

- GLUCAGEN HYPOKIT

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

Glucocard 01 Sensor Plus

Products Affected

- GLUCOCARD 01 SENSOR PLUS

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

Glucocard Expression Test

Products Affected

- GLUCOCARD EXPRESSION TEST

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

Glucocard Vital Test

Products Affected

- GLUCOCARD VITAL TEST

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

Glucocard X-Sensor

Products Affected

- GLUCOCARD X-SENSOR

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

GlucoCom Test

Products Affected

- GLUCOCOM TEST

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

Gonal-f

Products Affected

- GONAL-F

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gonal-f RFF

Products Affected

- GONAL-F RFF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gonal-f RFF Rediject

Products Affected

- GONAL-F RFF REDIJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise

Products Affected

- GRALISE ORAL TABLET 300 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of GABAPENTIN
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 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

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

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

Grastek

Products Affected

- GRASTEK

PA Criteria	Criteria Details
Covered Uses	Allergic rhinitis with or without conjunctivitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of allergic rhinitis with or without conjunctivitis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Claritin OTC, Zyrtec OTC, or Allegra OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GuanFACINE HCl ER

Products Affected

- *guanfacine hcl er*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Guardian REAL-Time System Ped

Products Affected

- GUARDIAN REAL-TIME SYSTEM PED

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

Halaven

Products Affected

- HALAVEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Halaven.html
Exclusion Criteria	
Required Medical 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

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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hemangeol

Products Affected

- HEMANGEOL

PA Criteria	Criteria Details
Covered Uses	Proliferating infantile hemangioma
Exclusion Criteria	History of asthma or bronchospasms
Required Medical Information	A documented diagnosis of proliferating infantile hemangioma requiring systemic therapy and documented all of the following: (1) Member was not born prematurely with a corrected age of less than 5 weeks, (2) Member does not weigh less than 2kg, have sustained heart rate less than 80 beats per minute, have greater than first degree heart block, or have decompensated heart failure, and (3) Member does not have sustained blood pressure less than 50/ 30mmHg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: July 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/sedative-hypnotics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Horizant

Products Affected

- HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG

ST Criteria	FOR POST-HERPTIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of gabapentin. FOR RESTLESS LESG SYNDROME: A documented contraindication, intolerance, allergy, or failure of gabapentin or ropinirole.
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Horizant

Products Affected

- HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG

ST Criteria	FOR POST-HERPTIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of gabapentin. FOR RESTLESS LESG SYNDROME: A documented contraindication, intolerance, allergy, or failure of gabapentin or ropinirole.
QL Criteria	1 tablet Per 2 Days
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
QL Criteria	2 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira

Products Affected

- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
QL Criteria	6 injections Per 28 Days
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 PREFILLED SYRINGE KIT 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
QL Criteria	6 injections Per 28 Days
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 PEN-INJECTOR KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
QL Criteria	6 injections Per 28 Days
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 PEN-INJECTOR KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
QL Criteria	6 injections Per 28 Days
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 PEN-INJECTOR KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Humira.html
QL Criteria	6 injections Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hydrocodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hydrocodone-Acetaminophen

Products Affected

- *hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hydrocodone-Ibuprofen

Products Affected

- *hydrocodone-ibuprofen oral tablet 10-200 mg*
- *hydrocodone-ibuprofen oral tablet 5-200 mg, 7.5-200 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HYDROmorphone HCl

Products Affected

- *hydromorphone hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HYDROmorphone HCl

Products Affected

- *hydromorphone hcl rectal*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HYDROmorphone HCl ER

Products Affected

- *hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 12 mg, 32 mg, 8 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

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

HYDROmorphone HCl ER

Products Affected

- *hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 16 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hyqvia

Products Affected

- HYQVIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	A documented diagnosis of osteoporosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
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

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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ibudone

Products Affected

- IBUDONE ORAL TABLET 5-200 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 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/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/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: September 21, 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/2017/MUSC/Ilaris.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ilaris (150mg Delivered)

Products Affected

- ILARIS (150MG DELIVERED)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imiquimod

Products Affected

- *imiquimod external*

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

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/2017/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 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Incruse Ellipta

Products Affected

- INCRUSE ELLIPTA

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

Indomethacin

Products Affected

- *indomethacin oral*

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

Infinity Blood Glucose Test

Products Affected

- INFINITY BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
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/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Intelence

Products Affected

- INTELENCE ORAL TABLET 100 MG, 25 MG

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

Intelence

Products Affected

- INTELENCE ORAL TABLET 200 MG

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

Intron A

Products Affected

- INTRON A

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Invokamet

Products Affected

- INVOKAMET

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

Invokamet XR

Products Affected

- INVOKAMET XR

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

Invokana

Products Affected

- INVOKANA

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

Ipratropium Bromide

Products Affected

- *ipratropium bromide nasal*

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

Irbesartan

Products Affected

- *irbesartan*

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

Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide*

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET CHEWABLE

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

Isentress HD

Products Affected

- ISENTRESS HD

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

Itraconazole

Products Affected

- *itraconazole oral*

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

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

Jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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 HOUR 100-1000 MG, 50-500 MG

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

Janumet XR

Products Affected

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

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

Januvia

Products Affected

- JANUVIA

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

Jardiance

Products Affected

- JARDIANCE

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

Jentadueto

Products Affected

- JENTADUETO

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

Jentadueto XR

Products Affected

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

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

Jentadueto XR

Products Affected

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

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

Jevtana

Products Affected

- JEVTANA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/jevtana.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jublia

Products Affected

- JUBLIA

PA Criteria	Criteria Details
Covered Uses	Onychomycosis due to dermatophyte
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one systemic (oral) alternative such as terbinafine, itraconazole, griseofulvin
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/CV/Antilipidemic Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Antilipidemic Agents_HOFH.html
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/CV/Antilipidemic Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Antilipidemic Agents_HOFH.html
QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Antilipidemic Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Antilipidemic Agents_HOFH.html
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kadian

Products Affected

- KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG, 40 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 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/2017/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kepivance

Products Affected

- KEPIVANCE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kerydin

Products Affected

- KERYDIN

PA Criteria	Criteria Details
Covered Uses	Onychomycosis due to dermatophyte
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (NOTE: This positive test should be within the last 3 - 6 months and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one systemic (oral) alternative such as terbinafine, itraconazole, griseofulvin
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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

Kineret

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Kineret.html
QL Criteria	1 syringe 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 HOUR 2.5-1000 MG

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

Kombiglyze XR

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Tradjenta or Jentadueto and either Januvia or Janumet
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/ENDO/antidiabetic 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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kroger Blood Glucose Test

Products Affected

- *kroger blood glucose test*

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

Kroger Premium Glucose Test

Products Affected

- *kroger premium glucose test*

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

Kroger Test

Products Affected

- *kroger test*

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

Kuvan

Products Affected

- KUVAN ORAL PACKET 500 MG
- KUVAN ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine

Products Affected

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

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

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

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

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

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release 15 mg*

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

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release 30 mg*

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

Lantus

Products Affected

- LANTUS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Levemir Vial
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 SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Levemir Vial
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, 20 MG, 40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or 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 contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
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 contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or 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

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/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	999 ML Per 999 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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: December 22, 2016 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/2017/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LevETIRAcetam ER

Products Affected

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

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

LevETIRAcetam ER

Products Affected

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

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

Levorphanol Tartrate

Products Affected

- *levorphanol tartrate oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Next Generation Test

Products Affected

- LIBERTY NEXT GENERATION TEST

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

Liberty Test

Products Affected

- *liberty test*

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

Lidocaine

Products Affected

- *lidocaine external ointment*

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

Lidocaine

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Covered Uses	pain associated with post-herpetic neuralgia
Exclusion Criteria	
Required Medical Information	Documented diagnosis of pain associated with post-herpetic neuralgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 patches Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lidocaine-Prilocaine

Products Affected

- *lidocaine-prilocaine external cream*

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

Linezolid

Products Affected

- *linezolid oral suspension reconstituted*

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

Linezolid

Products Affected

- *linezolid oral tablet*

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

Linzess

Products Affected

- LINZESS

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

Linzess

Products Affected

- LINZESS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of lactulose or polyethylene glycol
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

Livalo

Products Affected

- LIVALO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastain
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

Lorcet

Products Affected

- LORCET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lorcet HD

Products Affected

- LORCET HD

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Losartan Potassium

Products Affected

- *losartan potassium oral tablet 25 mg, 50 mg*

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

Lovastatin

Products Affected

- *lovastatin*

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

Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION
  0.01 %

ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 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/2017/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: January 11, 2017 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/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lupron Depot (1-Month)

Products Affected

- LUPRON DEPOT (1-MONTH)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lupron Depot (3-Month)

Products Affected

- LUPRON DEPOT (3-MONTH)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lupron Depot (4-Month)

Products Affected

- LUPRON DEPOT (4-MONTH)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lupron Depot (6-Month)

Products Affected

- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lupron Depot-Ped (1-Month)

Products Affected

- LUPRON DEPOT-PED (1-MONTH)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lupron Depot-Ped (3-Month)

Products Affected

- LUPRON DEPOT-PED (3-MONTH)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lyrica

Products Affected

- LYRICA

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	A diagnosis of epilepsy as adjunct therapy, diabetic peripheral neuropathy, post-herpetic neuropathy, Fibromyalgia with failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), or for neuropathic pain associated with spinal cord injury
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR A DIAGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY OR POST-HERPETIC NEUROPATHY: A documented contraindication, intolerance, allergy, or failure of gabapentin. FOR A DIAGNOSIS OF FIBROMYALGIA: A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SSRI, SNRI, gabapentin, or tramadol. FOR A DIAGNOSIS OF NEUROPATHIC PAIN ASSOCIATED WITH SPINAL CORD INJURY: A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SNRI, gabapentin, or tramadol.
Notes/ References	Annual Review: 05/2017

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 50 mg*

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

Maprotiline HCl

Products Affected

- *maprotiline hcl oral tablet 75 mg*

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 180 MG, 300 MG, 360 MG

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 240 MG

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

Mavyret

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/GI/hepatitis_c.html
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Meijer Blood Glucose Test

Products Affected

- *meijer blood glucose test*

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

Meijer Premium Glucose Test

Products Affected

- *meijer premium glucose test*

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

Mekinist

Products Affected

- MEKINIST ORAL TABLET 0.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Memantine HCl

Products Affected

- *memantine hcl oral*

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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Menopur

Products Affected

- MENOPUR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Menostar

Products Affected

- MENOSTAR

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

Meperidine HCl

Products Affected

- *meperidine hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 1.2 gm*

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

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 800 mg*

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

Metadate ER

Products Affected

- METADATE ER ORAL TABLET EXTENDED RELEASE 20 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	3 tabs Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

MetFORMIN HCl ER (OSM)

Products Affected

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

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

MetFORMIN HCl ER (OSM)

Products Affected

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

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

Methadone HCl

Products Affected

- *methadone hcl oral concentrate*
- *methadone hcl oral tablet soluble*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. (4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) and the patient will be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadone HCl

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. (4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) and the patient will be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information
Other Criteria	
QL Criteria	60 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadone HCl

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. (4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) and the patient will be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information
Other Criteria	
QL Criteria	30 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadone HCl

Products Affected

- *methadone hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. (4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) and the patient will be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information
Other Criteria	
QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadone HCl Intensol

Products Affected

- METHADONE HCL INTENSOL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. (4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) and the patient will be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval).

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methamphetamine HCl

Products Affected

- *methamphetamine hcl*

QL Criteria	4 tabs Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet chewable*

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

Methylphenidate HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	3 tabs Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	1 cap Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la)*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	1 cap Per 1 Day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la)*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 26, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metoprolol Succinate ER

Products Affected

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

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

Metoprolol Succinate ER

Products Affected

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

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

Metoprolol Succinate ER

Products Affected

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

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

Miacalcin

Products Affected

- MIACALCIN INJECTION

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Microdot Test

Products Affected

- MICRODOT TEST

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

Mimvey Lo

Products Affected

- MIMVEY LO

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

Mircera

Products Affected

- MIRCERA INJECTION SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mirtazapine

Products Affected

- *mirtazapine 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

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

Mirvaso

Products Affected

- MIRVASO

PA Criteria	Criteria Details
Covered Uses	persistent (nontransient) facial erythema of acne rosacea
Exclusion Criteria	
Required Medical Information	A documented diagnosis of persistent (nontransient) facial erythema of acne rosacea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented step through topical metronidazole
Notes/ References	
Revision Date	Prior Authorization: October 13, 2016 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 modafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patient's ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and patient must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

ST Criteria	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: A documented contraindication, intolerance, allergy, or failure of an adequate trial of at least two immediate release stimulants.
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 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

Products Affected

- *morphine sulfate oral solution*
- *morphine sulfate rectal*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate

Products Affected

- *morphine sulfate oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate (Concentrate)

Products Affected

- *morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral capsule extended release 24 hour*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral tablet extended release*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

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PA Criteria	Criteria Details
Other Criteria	
QL Criteria	4 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral tablet extended release*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate ER Beads

Products Affected

- *morphine sulfate er beads*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

ST Criteria	A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mozobil

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Mozobil.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 27, 2016 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

MyGlucoHealth Test

Products Affected

- MYGLUCOHEALTH TEST

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

Myobloc

Products Affected

- MYOBLOC

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myorisan

Products Affected

- MYORISAN ORAL CAPSULE 10 MG, 20 MG, 40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myrbetriq

Products Affected

- MYRBETRIQ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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 stable on anti-retroviral therapy, 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	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of at least one antimotility agent such as loperamide or atropine/diphenoxylate
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: May 25, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naftifine HCl

Products Affected

- *naftifine hcl*

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

Naftin

Products Affected

- NAFTIN EXTERNAL GEL 1 %

ST Criteria	A documented contraindication, intolerance, allergy, or failure of clotrimazole and econazole 1%
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/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: January 11, 2017 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: August 25, 2015 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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Namzaric

Products Affected

- NAMZARIC

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: August 25, 2015 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

Neulasta

Products Affected

- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupogen

Products Affected

- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupro

Products Affected

- NEUPRO

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

Neutek 2Tek Glucose/Pressure

Products Affected

- NEUTEK 2TEK GLUCOSE/PRESSURE

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

Neutek 2Tek Test

Products Affected

- NEUTEK 2TEK TEST

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

Nevirapine ER

Products Affected

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

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

Nevirapine ER

Products Affected

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

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

NexAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexIUM

Products Affected

- NEXIUM ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	A diagnosis of Zollinger-Ellison syndrome, uncomplicated gastroesophageal reflux desease (GERD) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, short term court of high dose= 3 months
Other Criteria	
ST Criteria	ONCE DAILY DOSING OF RABEPRAZOLE (20mg), DEXILANT (60mg), AND NEXIUM (40mg): A documented contraindication, intolerance, allergy, or failure of Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. HIGH DOSE NEXIUM (80mg) OR HIGH DOSE RABEPRAZOLE (40mg): A documented contraindication, intolerance, allergy, or failure of 80mg/day of Prilosec OTC/omeprazole or pantoprazole or though 60mg/day of Prevacid 24H OTC.
QL Criteria	1 packet Per 1 Day

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexIUM 24HR

Products Affected

- NEXIUM 24HR ORAL CAPSULE DELAYED RELEASE

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

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

Nifediac CC

Products Affected

- NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG

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

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

Nisoldipine ER

Products Affected

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

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

Nisoldipine ER

Products Affected

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

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

Noritate

Products Affected

- NORITATE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of metronidazole gel and metronidazole cream 0.75%
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 II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Novarel

Products Affected

- NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG

Products Affected

- NOVOLOG

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

NovoLOG FlexPen

Products Affected

- NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
Notes/ References	
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 contraindication, intolerance, allergy, or failure of a Humulin or Humalog product
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 SUSPENSION PEN-INJECTOR

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

NovoLOG PenFill

Products Affected

- NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE

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

Noxafil

Products Affected

- NOXAFIL ORAL SUSPENSION

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

ST Criteria	FOR A DIAGNOSIS OF INVASIVE CANDIDIASIS: A documented contraindication, intolerance, allergy, or failure of fluconazole. FOR A DIAGNOSIS OF OROPHARYNGEAL CANDIDIASIS: A documented contraindication, intolerance, allergy, or failure of fluconazole or itraconazole
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 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/2017/MISC/Neumega.html
Exclusion Criteria	
Required Medical 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

Nucynta

Products Affected

- NUCYNTA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	120 tablets Per 30 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucynta ER

Products Affected

- NUCYNTA ER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

ST Criteria	FOR A DIGANOSIS OF CHRONIC PAIN: A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (genenic MS Contin). FOR A DIGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY (DPN): A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (MS Contin) and two of the following drug/drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant, tramadol, Lyrica, or a SNRI
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	Treatment of pseudobulbar affect in patients with amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS).
Exclusion Criteria	Treatment in other types of emotional lability (i.e. Alzheimers disease and other dementias).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 caps Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nulojix

Products Affected

- NULOJIX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/2017/ID/Nulojix.html
Exclusion Criteria	
Required Medical 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 17, 2016 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/2017/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 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Octreotide Acetate

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/ANEOPL/Odomzo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OLANZapine

Products Affected

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

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

OLANZapine

Products Affected

- *olanzapine oral tablet 2.5 mg*

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

OLANZapine

Products Affected

- *olanzapine oral tablet dispersible*

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

OLANZapine-FLUoxetine HCl

Products Affected

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

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

Olmesartan Medoxomil

Products Affected

- *olmesartan medoxomil oral*

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

Olmesartan Medoxomil-HCTZ

Products Affected

- *olmesartan medoxomil-hctz*

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

Olmesartan-Amlodipine-HCTZ

Products Affected

- *olmesartan-amlodipine-hctz*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
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 capsule 20-1100 mg*

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

Omnaris

Products Affected

- OMNARIS

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

Omnitrope

Products Affected

- OMNITROPE SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/ENDO/growthhormone.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Omnitrope

Products Affected

- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

On Call Plus Blood Glucose

Products Affected

- ON CALL PLUS BLOOD GLUCOSE

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

On Call Vivid Blood Glucose

Products Affected

- ON CALL VIVID BLOOD GLUCOSE

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

Onfi

Products Affected

- ONFI ORAL TABLET 10 MG, 20 MG

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

Onglyza

Products Affected

- ONGLYZA

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

Opana ER

Products Affected

- OPANA ER ORAL TABLET ER 12 HOUR ABUSE-DETERRENT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 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/2017/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: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oravig

Products Affected

- ORAVIG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of fluconazole, and either nystatin or clotrimazole troche
QL Criteria	14 tabs Per 1 fill
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/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/2017/MUSC/Orencia.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orencia

Products Affected

- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Orencia.html
QL Criteria	4 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orencia

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Orencia.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

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/2017/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/2017/MUSC/Orencia.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

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/2017/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: December 22, 2016 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/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oseltamivir Phosphate

Products Affected

- *oseltamivir phosphate oral capsule*

QL Criteria	20 capsules Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Osphena

Products Affected

- OSPHENA

PA Criteria	Criteria Details
Covered Uses	moderate to severe dyspareunia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe dyspareunia in a female patient
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an estrogen product such as estradiol, estropipate, or Premarin
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 30, 2017 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/2017/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/2017/MUSC/Otezla.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

Otezla

Products Affected

- OTEZLA ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Otezla.html
QL Criteria	1 pack Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ovidrel

Products Affected

- OVIDREL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxaydo

Products Affected

- OXAYDO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG

ST Criteria	A documented step through immediate release oxcarbazepine
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 HOUR 600 MG

ST Criteria	A documented step through immediate release oxcarbazepine
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

Oxybutynin Chloride ER

Products Affected

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

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

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er oral tablet extended release 24 hour 5 mg*

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

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

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QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl ER

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxycodone-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxycodone-Aspirin

Products Affected

- *oxycodone-aspirin oral tablet 4.8355-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxycodone-Ibuprofen

Products Affected

- *oxycodone-ibuprofen*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCONTIN

Products Affected

- OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Xtampza ER
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl

Products Affected

- *oxymorphone hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone.
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyMORphone HCl ER

Products Affected

- *oxymorphone hcl er*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

ST Criteria	A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin)
QL Criteria	4 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or 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

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hour 9 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
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

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/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pancreaze

Products Affected

- PANCREAZE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 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 10 mg, 20 mg*

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

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 mg*

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of paroxetine
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pegasys

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG

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

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG

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

Pentazocine-Naloxone HCl

Products Affected

- *pentazocine-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Perforomist

Products Affected

- PERFOROMIST

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	Documented physical limitation that prevents the use of a non-nebulized long-acting bronchodilator with or without use of a spacer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	60 vials Per 1 fill
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pertzye

Products Affected

- PERTZYE

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

Pharmacist Choice Autocode

Products Affected

- PHARMACIST CHOICE AUTOCODE

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

Phenoxybenzamine HCl

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 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

Plegridy

Products Affected

- PLEGRIDY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy

Products Affected

- PLEGRIDY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	2 syringes Per 28 months
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	1 kit Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK
  SUBCUTANEOUS SOLUTION
  PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PocketChem EZ Test

Products Affected

- POCKETCHEM EZ TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 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/2017/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 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Praluent

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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/2017/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

Prasugrel HCl

Products Affected

- *prasugrel hcl*

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS) managed with percutaneous coronary intervention which includes unstable angina or non-ST elevation myocardial infarction or ST elevation myocardial infarction (MI)
Exclusion Criteria	History of Stroke or transient ischemic attack (TIA)
Required Medical Information	Member has a documented diagnosis of acute coronary syndrome (ACS) and is managed by percutaneous coronary intervention (PCI), which includes unstable angina, non-ST-elevation myocardial infarction (NSTEMI), or ST -elevation myocardial infarction (STEMI) managed with primary or delayed PCI and member has no prior history of stroke or transient ischemic attack (TIA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

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

Precision PCx

Products Affected

- PRECISION PCX

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

Precision PCX Plus Test

Products Affected

- PRECISION PCX PLUS TEST

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

Precision Point of Care Test

Products Affected

- PRECISION POINT OF CARE TEST

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

Precision QID Test

Products Affected

- PRECISION QID TEST

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

Precision Sof-Tact Test

Products Affected

- PRECISION SOF-TACT TEST

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

Precision Xtra Blood Glucose

Products Affected

- PRECISION XTRA BLOOD GLUCOSE

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

Prefest

Products Affected

- PREFEST

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

Pregnyl

Products Affected

- PREGNYL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prezista

Products Affected

- PREZISTA ORAL SUSPENSION

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

Prezista

Products Affected

- PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG

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

Prezista

Products Affected

- PREZISTA ORAL TABLET 800 MG

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

Procrit

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prodigy No Coding Blood Gluc

Products Affected

- PRODIGY NO CODING BLOOD GLUC

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

Progesterone Micronized

Products Affected

- *progesterone micronized oral*

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

Prolastin-C

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Proleukin

Products Affected

- PROLEUKIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Interleukin 2.html
Exclusion Criteria	
Required Medical 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

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/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected

- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 21, 2016 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

Prudoxin

Products Affected

- PRUDOXIN

QL Criteria	45 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pulmicort Flexhaler

Products Affected

- PULMICORT FLEXHALER

ST Criteria	A documented contraindication, intolerance, allergy, or failure of QVAR
QL Criteria	1 inhaler Per 1 month
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 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/2017/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	60 units Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl

Products Affected

- QNASL

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

Qsymia

Products Affected

- QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30kg/m2 or BMI greater than 27kg/m2 with one or more of the items in the required medical information section
Exclusion Criteria	Concomitant use of two or more anti-obesity agents, pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140mm Hg or diastolic blood pressure greater than 90mm Hg on more than one occasion), Dyslipidemia (LDL cholesterol greater than/= 160mg/dL: HDL cholesterol less than 35mg/dL: triglycerides greater than/= 400mg/dL), Type 2 Diabetes Mellitus, Coronary Heart Disease, or Obstructive Sleep Apnea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of phentermine cap or phendimetrazine tab
QL Criteria	1 capsule Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QUEtiapine Fumarate

Products Affected

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

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

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

QUEtiapine Fumarate

Products Affected

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

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

QUEtiapine Fumarate ER

Products Affected

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

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

QUEtiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg*

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

Quillivant XR

Products Affected

- QUILLIVANT XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant
QL Criteria	1 bottle Per 1 fill
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: September 26, 2017 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 II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	A diagnosis of Zollinger-Ellison syndrome, uncomplicated gastroesophageal reflux desease (GERD) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, short term court of high dose= 3 months
Other Criteria	
ST Criteria	ONCE DAILY DOSING OF RABEPRAZOLE (20mg), DEXILANT (60mg), AND NEXIUM (40mg): A documented contraindication, intolerance, allergy, or failure of Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. HIGH DOSE NEXIUM (80mg) OR HIGH DOSE RABEPRAZOLE (40mg): A documented contraindication, intolerance, allergy, or failure of 80mg/day of Prilosec OTC/omeprazole or pantoprazole or though 60mg/day of Prevacid 24H OTC.
QL Criteria	1 tab Per 1 Day

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Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 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

Rasagiline Mesylate

Products Affected

- *rasagiline mesylate oral*

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

Ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	20 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebetol

Products Affected

- REBETOL ORAL SOLUTION

QL Criteria	500 milliliters Per 1 prescription
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebif

Products Affected

- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebif Rebidose

Products Affected

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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	12 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebif Rebidose Titration Pack

Products Affected

- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 titration pack Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebif Titration Pack

Products Affected

- REBIF TITRATION PACK
  SUBCUTANEOUS SOLUTION
  PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 titration pack Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 21, 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

RefuAH Plus Blood Glucose Test

Products Affected

- REFUAH PLUS BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 04/2017
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 12 MG/0.6ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure,Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concommitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.6 ML Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure,Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concommitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.4 ML Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 19, 2017 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/2017/MUSC/Remicade.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
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/2017/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: December 22, 2016 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/2017/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/2017/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/2017/MISC/PCSK9.html
QL Criteria	1 syringe Per 1 month
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/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

Rescula

Products Affected

- RESCULA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reveal Blood Glucose Test

Products Affected

- REVEAL BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 04/2017
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/2017/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 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rexall Blood Glucose Test

Products Affected

- REXALL BLOOD GLUCOSE TEST

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

Rexulti

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD), Schizophrenia
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Major Depressive Disorder (MDD) or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 08/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 150 MG
- REYATAZ ORAL CAPSULE 300 MG

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

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 200 MG

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

Rightest GS100 Blood Glucose

Products Affected

- RIGHTEST GS100 BLOOD GLUCOSE

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

Rightest GS300 Blood Glucose

Products Affected

- RIGHTEST GS300 BLOOD GLUCOSE

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

Rightest GS550 Blood Glucose

Products Affected

- RIGHTEST GS550 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 04/2017
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	A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg
QL Criteria	1 tablet Per 28 Days
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

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

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

Risedronate Sodium

Products Affected

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

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

RisperiDONE

Products Affected

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

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

RisperiDONE

Products Affected

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

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

RisperiDONE

Products Affected

- *risperidone oral tablet 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 M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 0.5 MG, 1 MG, 2 MG

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

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 3 MG

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

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 4 MG

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

Rituxan

Products Affected

- RITUXAN INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Rituxan.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Rituxan.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

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 hour 12 mg*

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

ROPINIRole HCl ER

Products Affected

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

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

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastain
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

PA Criteria	Criteria Details
Covered Uses	Insomnia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of insomnia
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of either zolpidem tartrate or zalelpon, and through zolpidem tartrate extended-release
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 08/2017
Revision Date	Prior Authorization: July 18, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Rubraca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: January 09, 2017 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/2017/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 packs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sancuso

Products Affected

- SANCUSO

PA Criteria	Criteria Details
Covered Uses	Chemotherapy induced nausea and vomiting
Exclusion Criteria	Cancer patients with non-chemotherapy related nausea and vomiting, patients with radiation-induced nausea and vomiting, patients with pregnancy-related nausea and vomiting, patients with post-operative nausea and vomiting
Required Medical Information	Patient is currently receiving chemotherapy and remains symptomatic despite treatment with oral antiemetics
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of oral ondansetron or oral granisetron
QL Criteria	1 patch Per 1 fill
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saphris

Products Affected

- SAPHRIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or 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

Savella

Products Affected

- SAVELLA

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	A diagnosis of fibromyalgia and documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SSRI, SNRI, gabapentin, or tramadol
QL Criteria	2 tabs Per 1 Day
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: May 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella Titration Pack

Products Affected

- SAVELLA TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	A diagnosis of fibromyalgia and documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SSRI, SNRI, gabapentin, or tramadol
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: May 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Selzentry

Products Affected

- SELZENTRY ORAL SOLUTION

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

Selzentry

Products Affected

- SELZENTRY ORAL TABLET 150 MG

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

Selzentry

Products Affected

- SELZENTRY ORAL TABLET 25 MG

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

Selzentry

Products Affected

- SELZENTRY ORAL TABLET 75 MG

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

Sensipar

Products Affected

- SENSIPAR

PA Criteria	Criteria Details
Covered Uses	Secondary Hyperparathyroidism (HPT) in adult patients with chronic kidney disease (CKD) on dialysis, Hypercalcemia in adult patients with Parathyroid Carcinoma, or Hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of Secondary Hyperparathyroidism (HPT) in an adult patient with chronic kidney disease (CKD) on dialysis,Hypercalcemia in an adult patient with parathyroid carcinoma (PC), or Hypercalcemia in an adult patient with primary hyperparathyroidism for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: July 11, 2017 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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

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

Signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 amps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simponi

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Simponi.html
QL Criteria	1 pen Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2017/MUSC/Simponi_Aria.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
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

Simulect

Products Affected

- SIMULECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/Simulect.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: December 22, 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

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/2017/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 Days
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sivextro

Products Affected

- SIVEXTRO ORAL

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

Smartest Blood Glucose Test

Products Affected

- SMARTEST BLOOD GLUCOSE TEST

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

Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate*
- *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/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Solus V2 Test

Products Affected

- SOLUS V2 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 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/2017/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Spiriva HandiHaler

Products Affected

- SPIRIVA HANDIHALER

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

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Incruse
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 SOLUTION

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

ST Criteria	FOR A DIAGNOSIS OF ONYCHOMYCOSIS, TINEA BARBAE, TIBNEA CAPITIS, TINEA FAVOSA: A documented contraindication, intolerance, allergy, or failure of terbinafine. FOR A DIAGNOSIS OF TINEA CORPORIS, TINEA CRURIS, TINEA FACIEI, TINEA MANUUM, TINEA PEDIS: A documented contraindication, intolerance, allergy, or failure of a topical antifungal and terbinafine. FOR A DIAGNOSIS OF TINEA VERSICOLOR: A documented contraindication, intolerance, allergy, or failure of selenium sulfide and a topcial antifungal.
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2017 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/2017/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/2017/ANEOPL/Antineoplastics.html
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/ANEOPL/Antineoplastics.html
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stelara

Products Affected

- STELARA INTRAVENOUS PREFILLED SYRINGE
- STELARA SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stimate

Products Affected

- STIMATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/miscendocrine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stiolto Respimat

Products Affected

- STIOLTO RESPIMAT

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

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/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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	Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who 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 buccals Per 1 Day
Notes/ References	Annual Review: 02/2017

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Revision Date	Prior Authorization: February 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stribild

Products Affected

- STRIBILD

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Striverdi Respimat

Products Affected

- STRIVERDI RESPIMAT

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Chronic obstructive pulmonary disease (COPD
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Serevent
QL Criteria	1 inhaler Per 30 Days
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM

QL Criteria	2 films Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SulfaSALAzine

Products Affected

- *sulfasalazine oral*

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

Sulfazine

Products Affected

- SULFAZINE

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

SUMAtriptan

Products Affected

- *sumatriptan nasal*

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

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate oral*

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

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution 6 mg/0.5ml*

QL Criteria	10 vials 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 auto-injector 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 solution cartridge*

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

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/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sure Edge Test

Products Affected

- SURE EDGE TEST

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

SureChek Blood Glucose Test

Products Affected

- SURECHEK BLOOD GLUCOSE TEST

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

SureStep Pro Linearity

Products Affected

- SURESTEP PRO LINEARITY

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

Sure-Test EasyPlus Mini Test

Products Affected

- SURE-TEST EASYPLUS MINI TEST

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

Sutent

Products Affected

- SUTENT ORAL CAPSULE 12.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected

- SUTENT ORAL CAPSULE 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected

- SUTENT ORAL CAPSULE 37.5 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Symbicort

Products Affected

- SYMBICORT

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

SymlinPen 120

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA Approved uses
Exclusion Criteria	Poor compliance with current insulin regimen, Poor compliance with prescribed self-blood glucose monitorings, An A1C greater than 9%, Recurrent severe hypoglycemia requiring assistance during the previous 6 months, Presence of hypoglycemia unawareness, Confirmed diagnosis of gastroparesis, Need for medications that stimulate GI motility , Patient is less than 18 years old, Concurrent use with other oral antidiabetic medications (except metformin and sulfonylureas) or drugs that alter gastrointestinal motility
Required Medical Information	A documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin). For extended renewals: a documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin), and the patient demonstrated an expected reduction in HbA1c since starting this therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	initial: 6 months - extended: 12 months
Other Criteria	
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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SymlinPen 60

Products Affected

- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

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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/2017/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 21, 2016 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/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synjardy

Products Affected

- SYNJARDY

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

Synjardy XR

Products Affected

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

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

Synjardy XR

Products Affected

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

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

Synribo

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/ANEOPL/Antineoplastics.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/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/2017/MISC/metabolic_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taclonex

Products Affected

- TACLONEX EXTERNAL SUSPENSION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of calcipotriene and a medium to high potency topical steroid
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tacrolimus

Products Affected

- *tacrolimus external*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid (triamcinolone azcetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment)
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tacrolimus

Products Affected

- *tacrolimus external*

ST Criteria	A documented step through 2 weeks (14 days) of one preferred alternative topical corticosteroid (triamcinolone azcetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment)
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 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/2017/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: September 21, 2016 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

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must have an A1C level is greater than 6.5%,
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Targretin

Products Affected

- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Targretin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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/2017/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/2017/ANEOPL/Antineoplastics.html
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tazarotene

Products Affected

- *tazarotene external*

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

Tazorac

Products Affected

- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin
Notes/ References	
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 120 MG, 180 MG, 300 MG, 360 MG

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

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG

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

Tecfidera

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/CNS/multiple_sclerosis.html
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/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/2017/GI/hepatitis_c.html
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tekturna

Products Affected

- TEKTURNA

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

Tekturna HCT

Products Affected

- TEKTURNA 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

Telcare Blood Glucose Test

Products Affected

- TELCARE BLOOD GLUCOSE TEST

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

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

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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testopel

Products Affected

- TESTOPEL

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who 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	
Notes/ References	

Revision Date	Prior Authorization: February 08, 2017 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	Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who 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	60 grams Per 1 fill
Notes/ References	Annual Review: 02/2017

2017 Aetna Leap Pharmacy Drug Guide
Last Update 12/2017

Revision Date	Prior Authorization: February 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal gel 12.5 mg/act (1%)*
- *testosterone transdermal gel 50 mg/5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who 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	Annual Review: 02/2017

2017 Aetna Leap Pharmacy Drug Guide
Last Update 12/2017

Revision Date	Prior Authorization: February 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal gel 25 mg/2.5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who 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	

2017 Aetna Leap Pharmacy Drug Guide
Last Update 12/2017

Revision Date	Prior Authorization: February 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal solution*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who 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	6 milliliters Per 1 Day
Notes/ References	

2017 Aetna Leap Pharmacy Drug Guide
Last Update 12/2017

Revision Date	Prior Authorization: February 08, 2017 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/2017/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 31, 2017 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/2017/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 31, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TGT Blood Glucose Test

Products Affected

- *tgt blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	Annual Review: 04/2017
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/2017/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: September 21, 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/2017/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/2017/MISC/metabolic_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 2 mg*

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

TiaGABine HCl

Products Affected

- *tiagabine 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

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

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

Tobramycin

Products Affected

- *tobramycin inhalation*

QL Criteria	56 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tolterodine Tartrate

Products Affected

- *tolterodine tartrate*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

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

Toviaz

Products Affected

- TOVIAZ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR and through either Vesicare or Myrbetriq
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: 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/2017/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: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tradjenta

Products Affected

- TRADJENTA

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

TraMADol HCl

Products Affected

- *tramadol hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TraMADol HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tramadol
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TraMADol HCl ER (Biphasic)

Products Affected

- *tramadol hcl er (biphasic)*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

ST Criteria	A documented contraindication, intolerance, allergy, or failure of tramadol
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tramadol-Acetaminophen

Products Affected

- *tramadol-acetaminophen*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

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

Trelstar Mixject

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tresiba FlexTouch

Products Affected

- TRESIBA FLEXTOUCH

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

Triamcinolone Acetonide

Products Affected

- *triamcinolone acetonide nasal aerosol*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide
QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trintellix

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD)
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triptodur

Products Affected

- TRIPTODUR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triumeq

Products Affected

- TRIUMEQ

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

Trospium Chloride

Products Affected

- *trospium chloride*

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

Trospium Chloride ER

Products Affected

- *trospium chloride er*

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

TRUEtest Test

Products Affected

- TRUETEST TEST

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

TrueTrack Test

Products Affected

- TRUETRACK TEST

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

Trulicity

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must have an A1C level is greater than 6.5%,
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Truvada

Products Affected

- TRUVADA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tudorza Pressair

Products Affected

- TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED

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

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

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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uceris

Products Affected

- UCERIS 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

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

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

Ultima Test

Products Affected

- ULTIMA TEST

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

UltraTRAK PRO Test

Products Affected

- ULTRATRAK PRO TEST

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

UltraTRAK Ultimate Test

Products Affected

- ULTRATRAK ULTIMATE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 30 Days
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 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/2017/ID/antiviraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/ID/antiviraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/ID/antiviraltopical.html
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: September 21, 2016 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

Vectibix

Products Affected

- VECTIBIX INTRAVENOUS SOLUTION
  100 MG/5ML, 400 MG/20ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Vectibix.html
Exclusion Criteria	
Required Medical 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

Velcade

Products Affected

- VELCADE INJECTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Velcade.html
Exclusion Criteria	
Required Medical 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

Venlafaxine HCl

Products Affected

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

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

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

Venlafaxine HCl ER

Products Affected

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

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

Venlafaxine HCl ER

Products Affected

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

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

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/2017/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: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

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

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

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

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

VESIcare

Products Affected

- VESICARE

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

Vicodin

Products Affected

- VICODIN ORAL TABLET 5-300 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vicodin ES

Products Affected

- VICODIN ES ORAL TABLET 7.5-300 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vicodin HP

Products Affected

- VICODIN HP ORAL TABLET 10-300 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Victory AGM-4000 Test

Products Affected

- VICTORY AGM-4000 TEST

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

Victoza

Products Affected

- VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must have an A1C level is greater than 6.5%,
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR
QL Criteria	9 ML Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 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/2017/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/2017/GI/hepatitis_c.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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/2017/GI/hepatitis_c.html
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vigabatrin

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd

Products Affected

- VIIBRYD ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD)
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: April 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd Starter Pack

Products Affected

- VIIBRYD STARTER PACK

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD)
Exclusion Criteria	
Required Medical Information	A diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.)
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: April 20, 2017 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

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

Viread

Products Affected

- VIREAD ORAL TABLET

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

Vistogard

Products Affected

- VISTOGARD

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

Vocal Point Blood Glucose Test

Products Affected

- VOCAL POINT BLOOD GLUCOSE TEST

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

Voriconazole

Products Affected

- *voriconazole oral tablet*

PA Criteria	Criteria Details
Covered Uses	Fungal infections
Exclusion Criteria	
Required Medical Information	Diagnosis of invasive aspergillosis or with a serious systemic fungal infection caused by Scedosporium apiospermum and Fusarium spp., for the treatment of esophageal candidiasis that is resistant to treatment with fluconazole and itraconazole, or for the treatment of candidemia in non-neutropenic patients and the following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds that are unresponsive to treatment with fluconazole (Continue therapy for 14 days after the patient is afebrile and blood cultures are negative).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Invasive aspergillosis: 12 weeks, Oral Candidiasis: 3 weeks MAX, Candidemia: 12 weeks
Other Criteria	
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/GI/hepatitis_c.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 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/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 1.5 MG

PA Criteria	Criteria Details
Covered Uses	Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
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 CAPSULE 3 MG

PA Criteria	Criteria Details
Covered Uses	Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
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

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
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 THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyvanse

Products Affected

- VYVANSE

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Binge Eating Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) or Binge Eating Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyvanse

Products Affected

- VYVANSE

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Binge Eating Disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) or Binge Eating Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 14, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

WaveSense Presto

Products Affected

- WAVESENSE PRESTO

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

Wide-Seal Diaphragm 60

Products Affected

- WIDE-SEAL DIAPHRAGM 60

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

Wide-Seal Diaphragm 65

Products Affected

- WIDE-SEAL DIAPHRAGM 65

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

Wide-Seal Diaphragm 70

Products Affected

- WIDE-SEAL DIAPHRAGM 70

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

Wide-Seal Diaphragm 75

Products Affected

- WIDE-SEAL DIAPHRAGM 75

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

Wide-Seal Diaphragm 80

Products Affected

- WIDE-SEAL DIAPHRAGM 80

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

Wide-Seal Diaphragm 85

Products Affected

- WIDE-SEAL DIAPHRAGM 85

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

Wide-Seal Diaphragm 90

Products Affected

- WIDE-SEAL DIAPHRAGM 90

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

Wide-Seal Diaphragm 95

Products Affected

- WIDE-SEAL DIAPHRAGM 95

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

Xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xatmep

Products Affected

- XATMEP

PA Criteria	Criteria Details
Covered Uses	Treatment of acute lymphoblastic leukemia (ALL) or polyarticular juvenile idiopathic arthritis (pJIA) in pediatric patients
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Acute Lymphoblastic Leukemia (ALL) in a pediatric patient (18 years and younger) as part of a multi-phase, combination chemotherapy maintenance regimen or a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA) in pediatric patients (18 years and younger) who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs). Regardless of diagnosis, the patient must have a documented inability to swallow tablets/capsules.
Age Restrictions	Approved for those 18 years of age or younger
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: July 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeljanz

Products Affected

- XELJANZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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/2017/MUSC/Xeljanz_XeljanzXR.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

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/2017/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/2017/MUSC/Xeljanz_XeljanzXR.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

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/2017/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xiaflex

Products Affected

- XIAFLEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/duputrens_contracture_treatments.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: 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	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea.
Exclusion Criteria	Pregnancy, Severe hepatic impairment (child-Pugh C)
Required Medical Information	FOR HEPATIC ENCHEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days.
Other Criteria	
ST Criteria	FOR HEPATIC ENCEPHALOPATHY: A documented contraindication, intolerance, allergy, or failure of lactulose solution
QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG

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

Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 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

Xtampza ER

Products Affected

- XTAMPZA ER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 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/2017/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/2017/ANEOPL/Antineoplastics.html
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xylon

Products Affected

- XYLON

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	

Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/cataplexy-xyrem.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Yervoy

Products Affected

- YERVOY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/yervoy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zaleplon

Products Affected

- *zaleplon*

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

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/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html
QL Criteria	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid OTC

Products Affected

- ZEGERID OTC

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

Zelapar

Products Affected

- ZELAPAR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of selegiline
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/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zemaira

Products Affected

- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenatane

Products Affected

- ZENATANE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline
QL Criteria	2 capsules 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

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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zetonna

Products Affected

- ZETONNA

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

Ziana

Products Affected

- ZIANA

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

Zioptan

Products Affected

- ZIOPTAN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of latanoprost
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 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

Zoledronic Acid

Products Affected

- *zoledronic acid intravenous concentrate*
- *zoledronic acid intravenous solution*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet*
- *zolmitriptan oral tablet dispersible 2.5 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 tablets Per 30 Days
Notes/ References	
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*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
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

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

Zomig

Products Affected

- ZOMIG NASAL SOLUTION 5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan
QL Criteria	6 sprays Per 30 fills
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zonalon

Products Affected

- ZONALON

QL Criteria	45 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zontivity

Products Affected

- ZONTIVITY

PA Criteria	Criteria Details
Covered Uses	Reduction of the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD)
Exclusion Criteria	Do not use in patients with history of stroke, history of transient ischemic attack (TIA), or history of intracranial hemorrhage (ICH), or active pathological bleeding
Required Medical Information	Documented diagnosis or history of myocardial infarction (MI) or peripheral arterial disease (PAD) and concurrent use of aspirin or clopidogrel
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: July 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovirax

Products Affected

- ZOVIRAX EXTERNAL CREAM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of oral acyclovir
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/2017/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: September 21, 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/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zytiga

Products Affected

- ZYTIGA ORAL TABLET 250 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zytiga

Products Affected

- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/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: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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