

2017 Aetna Pharmacy Drug Guide - Five Tier Open Value Small Group Formulary
Abstral

Products Affected

- ABSTRAL

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

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
ST Criteria	<p>A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)</p>
QL Criteria	<p>120 tablets Per 30 Days</p>
Notes/References	<p>Annual Review: 06/2017</p>
Revision Date	<p>Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

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Acamprosate Calcium

Products Affected

- *acamprosate calcium*

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

Accolate

Products Affected

- ACCOLATE

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

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Accu-Chek Aviva Plus

Products Affected

- ACCU-CHEK AVIVA PLUS

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYSs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Accu-Chek Compact Plus Care

Products Affected

- ACCU-CHEK COMPACT PLUS CARE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Accu-Chek Multiclix Lancet Dev

Products Affected

- ACCU-CHEK MULTICLIX LANCET DEV

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Accu-Chek Nano SmartView

Products Affected

- ACCU-CHEK NANO SMARTVIEW

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

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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

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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

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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

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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

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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

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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

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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

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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

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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

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AcipHex Sprinkle

Products Affected

- ACIPHEX SPRINKLE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic RX or OTC proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2017

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Revision Date	Prior Authorization: November 21, 2016 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015
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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

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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	4 SYRINGES Per 28 DAYs
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Actoplus met XR

Products Affected

- ACTOPLUS MET XR

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

Aczone

Products Affected

- ACZONE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo and generic dapsone gel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: November 06, 2017 Quantity Limits: August 25, 2015

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Adagen

Products Affected

- ADAGEN

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

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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 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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

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Advair Diskus

Products Affected

- ADVAIR DISKUS INHALATION
AEROSOL POWDER BREATH
ACTIVATED 100-50 MCG/DOSE, 250-50
MCG/DOSE

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

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Advair Diskus

Products Affected

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

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

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Advair HFA

Products Affected

- ADVAIR HFA

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

Advate

Products Affected

- ADVATE

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

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Advocate Duo

Products Affected

- ADVOCATE DUO DEVICE

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

Adynovate

Products Affected

- *adynovate*

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

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Adyphren

Products Affected

- ADYPHREN

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

Adyphren Amp II

Products Affected

- ADYPHREN AMP II

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

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Adyphren II

Products Affected

- ADYPHREN II

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

Adzenys XR-ODT

Products Affected

- ADZENYS XR-ODT

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 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Aerospan

Products Affected

- AEROSPAN

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and QVAR
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: November 30, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Afeditab CR

Products Affected

- *afeditab cr 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

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Afeditab CR

Products Affected

- *afeditab cr oral tablet extended release 24 hour 60 mg*

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

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Afinitor Disperz

Products Affected

- AFINITOR DISPERZ

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

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Afrezza

Products Affected

- AFREZZA INHALATION POWDER 12 UNIT, 8 UNIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin, (2) In all Patients, no history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD), and (3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Afrezza

Products Affected

- AFREZZA INHALATION POWDER 4 & 8 & 12 UNIT, 4 (30) & 8 (60) UNIT, 4 (90) & 8 (90) UNIT, 4 UNIT, 8 (60)& 12 (30) UNIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin, (2) In all Patients, no history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD), and (3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: February 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Afrezza

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes, Type 2 Diabetes
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following: (1) In patients with type 1 diabetes, concomitant use of long-acting insulin, (2) In all Patients, no history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD), and (3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 02/2016
Revision Date	Prior Authorization: February 24, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Afstyla

Products Affected

- AFSTYLA

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

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AgaMatrix Presto

Products Affected

- AGAMATRIX PRESTO

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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AirDuo RespiClick 113/14

Products Affected

- AIRDUO RESPICLICK 113/14

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Breo, Dulera, Symbicort and propionate/salmeterol inhaler (generic Airduo)
QL Criteria	1 inhaler Per 30 Days
Notes/References	
Revision Date	Prior Authorization: May 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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AirDuo RespiClick 232/14

Products Affected

- AIRDUO RESPICLICK 232/14

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Breo, Dulera, Symbicort and propionate/salmeterol inhaler (generic Airduo)
QL Criteria	1 inhaler Per 30 Days
Notes/References	
Revision Date	Prior Authorization: May 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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AirDuo RespiClick 55/14

Products Affected

- AIRDUO RESPICLICK 55/14

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Breo, Dulera, Symbicort and propionate/salmeterol inhaler (generic Airduo)
QL Criteria	1 inhaler Per 30 Days
Notes/References	
Revision Date	Prior Authorization: May 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Akynzeo

Products Affected

- AKYNZEO

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of nausea and vomiting associated with cancer chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Akynzeo will be considered medically necessary for those members who have a documented chemotherapy regimen that requires more than two cycles of antiemetic per 30 days
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of a generic 5-HT3 receptor antagonist, such as granisetron or ondansetron, and one month of aprepitant
QL Criteria	2 capsules Per 1 month
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Albenza

Products Affected

- ALBENZA

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

Aldurazyme

Products Affected

- ALDURAZYME

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

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Alecensa

Products Affected

- ALECENSA

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

Products Affected

- *alendronate sodium oral tablet 10 mg, 40 mg, 5 mg*

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

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Alendronate Sodium

Products Affected

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

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

Alfuzosin HCl ER

Products Affected

- *alfuzosin hcl 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

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Alinia

Products Affected

- ALINIA ORAL SUSPENSION
RECONSTITUTED

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

Alinia

Products Affected

- ALINIA 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

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Almotriptan Malate

Products Affected

- *almotriptan malate*

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

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Alogliptin Benzoate

Products Affected

- *alogliptin benzoate*

QL Criteria	1 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

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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 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

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Alosetron HCl

Products Affected

- *alose tron hcl*

PA Criteria	Criteria Details
Covered Uses	severe diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	
Required Medical Information	Patient is female, and has a documented diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) including one or more of the following: frequent and severe abdominal pain/discomfort, frequent urgency or fecal incontinence or disability or restriction of daily activities due to IBS, AND patient has chronic IBS symptoms generally lasting 6 months or longer, AND anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each diphenoxylate/atropine and loperamide
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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ALPRAZolam ER

Products Affected

- *alprazolam er*

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

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ALPRAZolam XR

Products Affected

- *alprazolam 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

Altoprev

Products Affected

- ALTOPREV

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications: atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Alunbrig

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Alunbrig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: June 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Alvesco

Products Affected

- ALVESCO

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and QVAR
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: November 30, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Amcinonide

Products Affected

- *amcinonide external cream*
- *amcinonide external lotion*

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

Amitiza

Products Affected

- AMITIZA

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

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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

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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

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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*

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

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Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

QL Criteria	2 capsules 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

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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

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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 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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AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)(Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%

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QL Criteria	1 1.25 gm packet Per 1 day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)(Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%

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QL Criteria	5 grams-2 packets Per 1 day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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AndroGel Pump

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)(Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%

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QL Criteria	4 pumps Per 1 day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Anoro Ellipta

Products Affected

- ANORO ELLIPTA

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

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Antara

Products Affected

- ANTARA ORAL CAPSULE 30 MG, 90 MG

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

Anzemet

Products Affected

- ANZEMET ORAL

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

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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	<p>(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.</p>
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	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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ApexiCon E

Products Affected

- APEXICON E

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

Apidra

Products Affected

- APIDRA

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

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Apidra SoloStar

Products Affected

- APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
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 125 mg, 40 mg, 80 mg*

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

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Aprepitant

Products Affected

- *aprepitant oral capsule 80 & 125 mg*

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

Apriso

Products Affected

- APRISO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Aptensio XR

Products Affected

- APTENSIO 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 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 05/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Aptiom

Products Affected

- APTIOM ORAL TABLET 200 MG, 600 MG

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 TABS Per 1 DAYS
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: October 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Aptiom

Products Affected

- APTIOM ORAL TABLET 400 MG, 800 MG

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 TABS Per 1 DAYS
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: October 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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 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

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Arcalyst

Products Affected

- ARCALYST

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

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Arcapta Neohaler

Products Affected

- ARCAPTA NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent
QL Criteria	1 capsule Per 1 day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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ARIPiprazole

Products Affected

- *aripiprazole oral tablet 10 mg, 15 mg, 2 mg*
- *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	

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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

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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	

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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

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ArmonAir RespiClick 113

Products Affected

- ARMONAIR RESPICLICK 113

PA Criteria	Criteria Details
Covered Uses	Maintenance treatment of asthma as prophylactic therapy in patients 12 years of age and older.
Exclusion Criteria	Not indicated for the relief of acute bronchospasm
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and QVAR
QL Criteria	1 inhaler Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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ArmonAir RespiClick 232

Products Affected

- ARMONAIR RESPICLICK 232

PA Criteria	Criteria Details
Covered Uses	Maintenance treatment of asthma as prophylactic therapy in patients 12 years of age and older.
Exclusion Criteria	Not indicated for the relief of acute bronchospasm
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and QVAR
QL Criteria	1 inhaler Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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ArmonAir RespiClick 55

Products Affected

- ARMONAIR RESPICLICK 55

PA Criteria	Criteria Details
Covered Uses	Maintenance treatment of asthma as prophylactic therapy in patients 12 years of age and older.
Exclusion Criteria	Not indicated for the relief of acute bronchospasm
Required Medical Information	A documented diagnosis of Asthma
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and QVAR
QL Criteria	1 inhaler Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Arnuity Ellipta

Products Affected

- ARNUITY ELLIPTA

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

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Arymo ER

Products Affected

- ARYMO 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

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PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	120 tablets Per 3 Days
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Asacol HD

Products Affected

- ASACOL HD

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Delzicol, Lialda, or Pentasa
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

Ascomp-Codeine

Products Affected

- *ascomp-codeine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 0.5 MG

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

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Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 1 MG

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

Atacand

Products Affected

- ATACAND ORAL TABLET 32 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two preferred generic alternatives from the following agents: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Atomoxetine HCl

Products Affected

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

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

Atomoxetine HCl

Products Affected

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

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

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Atorvastatin Calcium

Products Affected

- *atorvastatin calcium 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

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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

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Atrovent HFA

Products Affected

- ATROVENT HFA

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

Aubagio

Products Affected

- AUBAGIO

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

Products Affected

- AUSTEDO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Austedo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Austedo.html
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 09, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Avandia

Products Affected

- AVANDIA ORAL TABLET 2 MG, 4 MG

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

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Avita

Products Affected

- *avita external cream*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	50 grams Per 1 fill
Notes/References	

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Avita

Products Affected

- *avita external gel*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo

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

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Avonex

Products Affected

- AVONEX

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

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

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Avonex Prefilled

Products Affected

- AVONEX PREFILLED
INTRAMUSCULAR PREFILLED
SYRINGE KIT

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

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Azilect

Products Affected

- AZILECT

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

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Azor

Products Affected

- AZOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand, Avapro, Cozaar, Micardis
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Balsalazide Disodium

Products Affected

- *balsalazide disodium*

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

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Banzel

Products Affected

- BANZEL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Basaglar KwikPen

Products Affected

- BASAGLAR KWIKPEN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Levemir and Tresiba
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Baxdela

Products Affected

- BAXDELA ORAL

PA Criteria	Criteria Details
Covered Uses	Treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by designated susceptible bacteria
Exclusion Criteria	Known hypersensitivity to Baxdela or other fluoroquinolones
Required Medical Information	A documented diagnosis of acute bacterial skin and skin structure infections (ABSSSI) caused by one the following susceptible pathogens: Gram-positive organisms include Staphylococcus aureus (including methicillin-resistant [MRSA] and methicillinsusceptible [MSSA] isolates), Staphylococcus haemolyticus, Staphylococcus lugdunensis, Streptococcus agalactiae, Streptococcus anginosus Group (including Streptococcus anginosus, Streptococcus intermedius, and Streptococcus constellatus), Streptococcus pyogenes, or Enterococcus faecalis. Gram-negative organisms include: Escherichia coli, Enterobacter cloacae, Klebsiella pneumoniae, and Pseudomonas aeruginosa.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	28 tablets Per 1 fill
Notes/References	
Revision Date	Prior Authorization: November 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bayer Contour Link Monitor

Products Affected

- BAYER CONTOUR LINK MONITOR

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bayer Contour Monitor

Products Affected

- BAYER CONTOUR MONITOR KIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bayer Contour Next EZ

Products Affected

- BAYER CONTOUR NEXT EZ

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bayer Contour next Link

Products Affected

- BAYER CONTOUR NEXT LINK

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bayer Contour Next Monitor

Products Affected

- BAYER CONTOUR NEXT MONITOR

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Beconase AQ

Products Affected

- BECONASE AQ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Belbuca

Products Affected

- BELBUCA

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	2 films Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Belsomra

Products Affected

- BELSOMRA

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

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Benicar

Products Affected

- BENICAR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two preferred generic alternatives from the following agents: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benicar HCT

Products Affected

- BENICAR HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or 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

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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

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Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

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

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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

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Betamethasone Dipropionate Aug

Products Affected

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

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

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Betamethasone Dipropionate Aug

Products Affected

- *betamethasone dipropionate aug external lotion*

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

Betamethasone Valerate

Products Affected

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

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

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

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Bethkis

Products Affected

- BETHKIS

QL Criteria	56 ampules Per 30 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bevespi Aerosphere

Products Affected

- BEVESPI AEROSPHERE

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Anoro Ellipta and Stiolto
QL Criteria	1 inhaler Per 30 Days
Notes/References	
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bevyxxa

Products Affected

- BEVYXXA

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE.
Exclusion Criteria	Active pathological bleeding, severe hypersensitivity reaction to Bevyxxa, or for anyone with prosthetic heart valves.
Required Medical Information	Member is requesting product for use of prophylaxis of VTE and is currently taking Bevyxxa during hospitalization and will be continuing therapy following discharge from the hospital.
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 enoxaparin or dalteparin, or heparin
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: October 04, 2017 Step Therapy: October 05, 2017 Quantity Limits: August 25, 2015

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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/ANEOP/L/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

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Bicalutamide

Products Affected

- *bicalutamide*

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

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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 one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: December 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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/ANEOPPL/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/ANEOPPL/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

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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/ANEOPPL/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/ANEOPPL/Antineoplastics.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

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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

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Botox Cosmetic

Products Affected

- BOTOX COSMETIC INTRAMUSCULAR SOLUTION RECONSTITUTED 50 UNIT

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

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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/inferility.html
Exclusion Criteria	
Required Medical Information	
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

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Breo Ellipta

Products Affected

- BREO ELLIPTA INHALATION
AEROSOL POWDER BREATH
ACTIVATED 100-25 MCG/INH

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

Breo Ellipta

Products Affected

- BREO ELLIPTA INHALATION
AEROSOL POWDER BREATH
ACTIVATED 200-25 MCG/INH

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

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Brilinta

Products Affected

- BRILINTA

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

Brisdelle

Products Affected

- BRISDELLE

PA Criteria	Criteria Details
Covered Uses	Moderate to severe vasomotor symptoms associated with menopause
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 28, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Briviact

Products Affected

- BRIVIACT ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizure
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 ML Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Briviact

Products Affected

- BRIVIACT ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Partial-onset seizure
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Brovana

Products Affected

- BROVANA

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	4 milliliters Per 1 day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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.
QL Criteria	4 ML Per 1 Day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: January 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	6 films Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 4.2-0.7 MG,
6.3-1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 films Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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PA Criteria	Criteria Details
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

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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 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

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BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

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

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BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

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 (XL)

Products Affected

- *bupropion hcl er (xl)*

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

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Butalbital-APAP-Caff-Cod

Products Affected

- *butalbital-apap-caff-cod*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(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	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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

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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

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

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Butrans

Products Affected

- BUTRANS

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

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Bydureon

Products Affected

- BYDUREON SUBCUTANEOUS PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
QL Criteria	1 pen 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

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Byetta 5 MCG Pen

Products Affected

- BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
QL Criteria	1 pen 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

Bystolic

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Treatment of hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic beta-blockers
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Bystolic

Products Affected

- BYSTOLIC ORAL TABLET 20 MG

PA Criteria	Criteria Details
Covered Uses	Treatment of hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic beta-blockers
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Byvalson

Products Affected

- BYVALSON

PA Criteria	Criteria Details
Covered Uses	Treatment of hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic beta-blockers and 2 generic angiotensin receptor blockers (ARBs)
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 08/2017
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Cabometyx

Products Affected

- CABOMETYX

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

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Calcipotriene

Products Affected

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

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

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Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

QL Criteria	1 bottle 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

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

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Canasa

Products Affected

- CANASA

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

Candesartan Cilexetil

Products Affected

- *candesartan cilexetil oral tablet 16 mg, 4 mg, 8 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

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Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-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

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/ANEOPPL/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

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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 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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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 tablet 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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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

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Cardizem LA

Products Affected

- CARDIZEM LA ORAL TABLET
EXTENDED RELEASE 24 HOUR 120 MG

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

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Cardura XL

Products Affected

- CARDURA XL

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

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

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Cartia XT

Products Affected

- *cartia xt oral capsule extended release 24 hour 240 mg*

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

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

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Celecoxib

Products Affected

- *celecoxib oral*

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

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 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Cesamet

Products Affected

- CESAMET

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

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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/inferility.html
Exclusion Criteria	
Required Medical Information	
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

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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

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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

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Chantix Starting Month Pak

Products Affected

- CHANTIX STARTING MONTH PAK

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

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	

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Cholbam

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Cholbam.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
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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/inferility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
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Cialis

Products Affected

- CIALIS ORAL TABLET 2.5 MG
- CIALIS ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	diagnosis of benign prostatic hyperplasia
Exclusion Criteria	Erectile dysfunction (ED) diagnosis is not covered except for members with ED benefit rider or Fully Insured (FI) members in the state of NY.
Required Medical Information	A documented diagnosis of diagnosis of benign prostatic hyperplasia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (30 tablets every 30 days)
Other Criteria	Member has failed two alpha blockers (e.g. Cardura (doxazosin), Hytrin (terazosin), Flomax (tamsulosin), Uroxatral (alfuzosin), Rapaflo (silodosin) and failed one 5-alpha reductase inhibitor (e.g. Avodart (dutasteride), Proscar (finasteride), Jalyn (dutasteride/tamsulosin).
QL Criteria	1 tablets Per 1 day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Ciclodan

Products Affected

- CICLODAN EXTERNAL SOLUTION

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

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Ciclopirox

Products Affected

- *ciclopirox external solution*

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

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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

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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

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

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Cinqair

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/RESP/Cinqair.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
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Cinryze

Products Affected

- CINRYZE

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

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Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 10 mg, 20 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

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Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 40 mg*

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

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Claravis

Products Affected

- *claravis*

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

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Clarinet-D 12 Hour

Products Affected

- CLARINEX-D 12 HOUR

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

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Clever Chek Auto-Code

Products Affected

- CLEVER CHEK AUTO-CODE

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

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Clever Choice Micro System

Products Affected

- CLEVER CHOICE MICRO SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Climara Pro

Products Affected

- CLIMARA PRO

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

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Clindamycin Phosphate

Products Affected

- *clindamycin phosphate external gel*
- *clindamycin phosphate external lotion*
- *clindamycin phosphate external solution*

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

Clobetasol Propionate

Products Affected

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

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

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Clobetasol Propionate

Products Affected

- *clobetasol propionate external foam*

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

Clobetasol Propionate

Products Affected

- *clobetasol propionate external liquid*

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

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Clobetasol Propionate

Products Affected

- *clobetasol propionate external lotion*

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

Clobetasol Propionate

Products Affected

- *clobetasol propionate external shampoo*

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

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Clobetasol Propionate

Products Affected

- *clobetasol propionate external solution*

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

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Clobetasol Propionate E

Products Affected

- *clobetasol propionate e*

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

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Clobetasol Propionate Emulsion

Products Affected

- *clobetasol propionate emulsion*

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

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Clodan

Products Affected

- *clodan external shampoo*

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

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CloNIDine HCl ER

Products Affected

- *clonidine 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	
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate 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

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CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

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CloZAPine

Products Affected

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

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CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

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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

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Coagadex

Products Affected

- COAGADEX

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

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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

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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

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Colchicine

Products Affected

- *colchicine oral*

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

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CombiPatch

Products Affected

- COMBIPATCH

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

Combivent Respimat

Products Affected

- COMBIVENT RESPIMAT

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

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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 kits 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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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/ANEOPPL/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 caupsules 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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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 kits 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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Complera

Products Affected

- COMPLERA

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

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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

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Cordran

Products Affected

- CORDRAN EXTERNAL TAPE

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

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Coreg CR

Products Affected

- COREG CR

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

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, nebulolol) 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 one of the following: ACE Inhibitor or ACE Inhibitor/HCTZ combination or Angiotensin-Receptor Blocker or Angiotensin-Receptor Blocker/HCTZ combination
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: July 25, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Cormax Scalp Application

Products Affected

- CORMAX SCALP APPLICATION

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

Cosentyx

Products Affected

- COSENTYX

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

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Cosentyx Sensoready Pen

Products Affected

- COSENTYX SENSOREADY PEN
SUBCUTANEOUS SOLUTION AUTO-
INJECTOR 150 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/Cosentyx.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Cosentyx.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Cotellic

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	63 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Cotempla XR-ODT

Products Affected

- COTEMPLA XR-ODT

PA Criteria	Criteria Details
Covered Uses	Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in pediatric patients 6 to 17 years of age.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
Age Restrictions	Approved for patients 6 to 17 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

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Crestor

Products Affected

- CRESTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two generic statin medications: atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Cuprimine

Products Affected

- CUPRIMINE ORAL CAPSULE 250 MG

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

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CVS Nicotine

Products Affected

- *cvs nicotine transdermal patch 24 hour*

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

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CVS Nicotine Polacrilex

Products Affected

- *cvs nicotine polacrilex mouth/throat lozenge*
4 mg

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

CVS NTS Step 1

Products Affected

- *cvs nts step 1*

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

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Cycloset

Products Affected

- CYCLOSET

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

Cystadane

Products Affected

- CYSTADANE

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

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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

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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/opthalmic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ML Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 EA 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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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

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Daliresp

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Breo, Symbicort, Anoro, Stiolto, Incruse, or Spiriva
QL Criteria	1 tablet 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

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Dapsone

Products Affected

- *dapsone external*

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

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Darifenacin Hydrobromide ER

Products Affected

- *darifenacin hydrobromide er*

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

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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 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 patch Per 1 day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Delzicol

Products Affected

- DELZICOL

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

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

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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

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Desloratadine

Products Affected

- *desloratadine*

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

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Desonide

Products Affected

- *desonide external*

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

Desoximetasone

Products Affected

- *desoximetasone external*

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

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Desoximetasone

Products Affected

- *desoximetasone external*

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

Desvenlafaxine ER

Products Affected

- *desvenlafaxine er*

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
QL Criteria	1 TB24 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

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Desvenlafaxine Succinate ER

Products Affected

- *desvenlafaxine succinate er*

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 05/2017

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Dexilant

Products Affected

- DEXILANT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic RX or OTC proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2017

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Revision Date	Prior Authorization: November 21, 2016 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015
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Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

QL Criteria	2 capsules 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

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Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

QL Criteria	40 milliliters 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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate 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

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Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

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

DiazePAM

Products Affected

- *diazepam rectal*

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

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Diclegis

Products Affected

- DICLEGIS

PA Criteria	Criteria Details
Covered Uses	Nausea and vomiting in pregnant women
Exclusion Criteria	
Required Medical Information	A documented diagnosis of nausea and vomiting in a pregnant woman who does not respond to conservative management (i.e. trigger avoidance, small frequent meals, etc) and a documented contraindication, intolerance, allergy, or failure of an adequate trial of one week of any of the following: otc doxylamine, or otc pyridoxine (vit B6), or metoclopramide, or promethazine, or ondansetron
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 01, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 1 %*

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

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Differin

Products Affected

- DIFFERIN EXTERNAL LOTION

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

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Dificid

Products Affected

- DIFICID

QL Criteria	20 tablets 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

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Diflorasone Diacetate

Products Affected

- *diflorasone diacetate external*

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

Dihydroergotamine Mesylate

Products Affected

- *dihydroergotamine mesylate nasal*

ST Criteria	A documented step through one month each of generic Migranal and two of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan
QL Criteria	9 ML Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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DiltiaZEM CD

Products Affected

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

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

Diltiazem HCl ER

Products Affected

- *diltiazem hcl er oral capsule extended release 12 hour 120 mg*
- *diltiazem hcl er 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

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Diltiazem HCl ER

Products Affected

- *diltiazem hcl er 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 Beads

Products Affected

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

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Diltiazem HCl ER Beads

Products Affected

- *diltiazem hcl er beads 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 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 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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DilTIAZem HCl ER Coated Beads

Products Affected

- *diltiazem hcl er coated beads 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 Coated Beads

Products Affected

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

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

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Dilt-XR

Products Affected

- *dilt-xr 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

Dilt-XR

Products Affected

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

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

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Dipentum

Products Affected

- DIPENTUM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Dolophine

Products Affected

- DOLOPHINE ORAL TABLET 10 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

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

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Donepezil HCl

Products Affected

- *donepezil hcl oral tablet 10 mg*

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	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Donepezil HCl

Products Affected

- *donepezil hcl oral tablet 23 mg, 5 mg*
- *donepezil hcl oral tablet dispersible*

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

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Doxepin HCl

Products Affected

- *doxepin hcl external*

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

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Doxercalciferol

Products Affected

- *doxercalciferol oral*

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

Dronabinol

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Anorexia associated with weight loss in patients with AIDS, or Chemotherapy-induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Duavee

Products Affected

- DUAVEE

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

Dulera

Products Affected

- DULERA

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

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DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 20 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

DULoxetine HCl

Products Affected

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

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

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DULoxetine HCl

Products Affected

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

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

Dupixent

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Dupixent.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: May 09, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Durolane

Products Affected

- DUROLANE

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

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Dutasteride

Products Affected

- *dutasteride*

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

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Duzallo

Products Affected

- DUZALLO

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperuricemia associated with gout in patients who have not achieved target serum uric acid levels with a medically appropriate daily dose of allopurinol alone.
Exclusion Criteria	For the treatment of asymptomatic hyperuricemia, severe renal impairment, end stage renal disease, kidney transplant recipients, or patients on dialysis, tumor lysis syndrome or Lesch-Nyhan syndrome, or for anyone with a known hypersensitivity to allopurinol, including previous occurrence of skin rash.
Required Medical Information	A documented diagnosis of hyperuricemia associated with gout and the member has a documented trial of allopurinol and has not achieved target serum uric acid levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of allopurinol or febuxostat
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: October 03, 2017 Step Therapy: October 04, 2017 Quantity Limits: August 25, 2015

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Dyanavel XR

Products Affected

- DYANAVEL 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 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	240 ML Per 30 days
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Dysport

Products Affected

- DYSPOORT

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

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Econazole Nitrate

Products Affected

- *econazole nitrate external*

QL Criteria	85 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Edarbi

Products Affected

- EDARBI

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two preferred generic alternatives from the following agents: candesartan, eprosartan, irbesartan, losartan, valsartan, olmesartan, or telmisartan
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

Edarbyclor

Products Affected

- EDARBYCLOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any two preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, olmesartan/hctz, or 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

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Edurant

Products Affected

- EDURANT

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

Effient

Products Affected

- EFFIENT

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	Annual Review: 04/2017
Revision Date	Prior Authorization: May 22, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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	
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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*

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

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Elidel

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis
Exclusion Criteria	
Required Medical Information	FOR MEMBERS LESS THAN 2 YEARS OF AGE: Covered for the treatment of mild to moderate atopic dermatitis (eczema) for short-term use (up to 3 months). FOR MEMBERS OVER 2 YEARS OF AGE: A documented diagnosis of atopic dermatitis (eczema) and has a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for their condition, or they are being treated for atopic dermatitis (eczema) in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Less than 2 years of age: 3 months. Over 2 years of age: 1 year.
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patients condition
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: October 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Eligard

Products Affected

- ELIGARD

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

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Elmiron

Products Affected

- ELMIRON

QL Criteria	90 capsules Per 30 Days
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

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PA Criteria	Criteria Details
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

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Emend

Products Affected

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

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

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Emsam

Products Affected

- EMSAM

QL Criteria	1 patch 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

Emtriva

Products Affected

- EMTRIVA ORAL CAPSULE

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

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Emverm

Products Affected

- EMVERM

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

Enablex

Products Affected

- ENABLEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Vesicare and Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Enablex

Products Affected

- ENABLEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Vesicare and Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 tablet Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 25 MG/0.5ML

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

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Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 50 MG/ML

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

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Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED

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

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Enbrel Mini

Products Affected

- ENBREL MINI

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

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

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Endocet

Products Affected

- *endocet oral tablet 10-325 mg, 5-325 mg*
- *endocet oral tablet 7.5-325 mg*
- ENDOCET ORAL TABLET 2.5-325 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	

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PA Criteria	Criteria Details
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

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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

Enstilar

Products Affected

- ENSTILAR

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

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Entecavir

Products Affected

- *entecavir*

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

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

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Entresto

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	Heart Failure
Exclusion Criteria	Known or suspected pregnancy
Required Medical Information	A documented diagnosis of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 08/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Entyvio

Products Affected

- ENTYVIO

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

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Epaned

Products Affected

- EPANED ORAL SOLUTION

QL Criteria	1 bottle Per 30 Days
Notes/ References	Annual Review: 08/2017
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	
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

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EPINEPHrine

Products Affected

- *epinephrine injection solution auto-injector*

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

EpiPen 2-Pak

Products Affected

- EPIPEN 2-PAK INJECTION SOLUTION
AUTO-INJECTOR

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

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EpiPen Jr 2-Pak

Products Affected

- EPIPEN JR 2-PAK INJECTION
SOLUTION AUTO-INJECTOR

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

EPIsnap

Products Affected

- EPISNAP

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

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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/Erythroipoiesis_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

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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

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Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

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

EQ Nicotine

Products Affected

- *eq nicotine transdermal*

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

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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 capsule 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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Esbriet

Products Affected

- ESBRIET ORAL CAPSULE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2017/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	9 EA 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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Esbriet

Products Affected

- ESBRIET ORAL TABLET 267 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2017/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	9 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Esbriet

Products Affected

- ESBRIET ORAL TABLET 801 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2017/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral solution*

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

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

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Escitalopram Oxalate

Products Affected

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

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

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Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium oral capsule delayed release 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

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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

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Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

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

Estrogel

Products Affected

- ESTROGEL

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

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Eszopiclone

Products Affected

- *eszopiclone*

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

Euflexxa

Products Affected

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

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Evamist

Products Affected

- EVAMIST

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

Evekeo

Products Affected

- EVEKEO

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD), Narcolepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) OR Narcolepsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	120 tablets Per 30 Days
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: January 25, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Exalgo

Products Affected

- EXALGO ORAL TABLET ER 24 HOUR
ABUSE-DETERRENT 32 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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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Exforge HCT

Products Affected

- EXFORGE HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine with 2 of the following (brand or generic if available): Atacand HCT, Avalide, Hyzaar, Micardis HCT
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exjade

Products Affected

- EXJADE

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

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

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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

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Ezetimibe-Simvastatin

Products Affected

- *ezetimibe-simvastatin*

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

Fabior

Products Affected

- FABIOR

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

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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

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FaLessa

Products Affected

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

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

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Famciclovir

Products Affected

- *famciclovir oral tablet 125 mg, 250 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

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Famciclovir

Products Affected

- *famciclovir oral tablet 500 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

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Fanapt

Products Affected

- FANAPT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Fanapt Titration Pack

Products Affected

- FANAPT TITRATION PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Farxiga

Products Affected

- FARXIGA

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

Farydak

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 EA Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Faslodex

Products Affected

- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML

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

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Felodipine ER

Products Affected

- *felodipine 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

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Femring

Products Affected

- FEMRING

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

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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

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Fenofibrate

Products Affected

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

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

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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	<p>(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.</p>
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	20 patches Per 30 Days
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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FentaNYL Citrate

Products Affected

- *fentanyl citrate buccal*

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

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

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Fentora

Products Affected

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

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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, 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

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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/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

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Fetzima

Products Affected

- FETZIMA

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 05/2017

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Fetzima Titration

Products Affected

- FETZIMA TITRATION

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 CP24 Per 1 DAYS
Notes/References	Annual Review: 05/2017

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Fiasp

Products Affected

- FIASP

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

Fiasp FlexTouch

Products Affected

- FIASP FLEXTOUCH

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

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Fibricor

Products Affected

- FIBRICOR

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

Finasteride

Products Affected

- *finasteride oral tablet 5 mg*

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member is greater than 50 years old or has diagnosis of BPH (Benign Prostatic Hyperplasia). For female members, must have a documented diagnosis of hirsutism secondary to ovarian or adrenal dysfunction (for example, polycystic ovary syndrome, adrenal or ovarian tumor)and must not be pregnant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: October 25, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Fioricet/Codeine

Products Affected

- FIORICET/CODEINE ORAL CAPSULE
50-300-40-30 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	

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PA Criteria	Criteria Details
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

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Firmagon

Products Affected

- FIRMAGON

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

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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

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Flolan

Products Affected

- FLOLAN

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

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Flovent Diskus

Products Affected

- FLOVENT DISKUS

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

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Flovent HFA

Products Affected

- FLOVENT HFA

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

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Fluocinolone Acetonide

Products Affected

- *fluocinolone acetonide external cream*

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

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Fluocinolone Acetonide

Products Affected

- *fluocinolone acetonide external cream*
- *fluocinolone acetonide external ointment*

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

Fluocinonide

Products Affected

- *fluocinonide external cream 0.05 %*
- *fluocinonide external ointment*
- *fluocinonide external gel*

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

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Fluocinonide

Products Affected

- *fluocinonide external cream 0.1 %*
- *fluocinonide external solution*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 10 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

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FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

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FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 40 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

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FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

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FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

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FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 60 mg*

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

Fluticasone Propionate

Products Affected

- *fluticasone propionate external cream*

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

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Fluticasone-Salmeterol

Products Affected

- *fluticasone-salmeterol*

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

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Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

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Fluvoxamine Maleate

Products Affected

- *fluvoxamine maleate oral tablet 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

Fluvoxamine Maleate

Products Affected

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

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Fluvoxamine Maleate ER

Products Affected

- *fluvoxamine maleate er*

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

Focalin XR

Products Affected

- FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 25 MG,
EXTENDED RELEASE 24 HOUR 20 MG 35 MG
- FOCALIN XR ORAL CAPSULE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules 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

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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

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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

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FORA D10 2-in-1 Monitor

Products Affected

- FORA D10 2-IN-1 MONITOR

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

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FORA D15g 2-in-1 Monitor

Products Affected

- FORA D15G 2-IN-1 MONITOR

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

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FORA D20 2-in-1 Monitor

Products Affected

- FORA D20 2-IN-1 MONITOR

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

Forteo

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION
600 MCG/2.4ML

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

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Fosamax Plus D

Products Affected

- FOSAMAX PLUS D

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	4 tablets 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

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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

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FreeStyle Flash System

Products Affected

- FREESTYLE FLASH SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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FreeStyle Freedom Lite

Products Affected

- FREESTYLE FREEDOM LITE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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FreeStyle InsuLinx System

Products Affected

- FREESTYLE INSULINX SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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 Precision Neo Test

Products Affected

- FREESTYLE PRECISION NEO 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

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FreeStyle System

Products Affected

- FREESTYLE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Frova

Products Affected

- FROVA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of three of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan
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

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Frovatriptan Succinate

Products Affected

- *frovatriptan succinate*

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

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Fuzeon

Products Affected

- FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED

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

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Fycompa

Products Affected

- FYCOMPA ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	A diagnosis of partial-onset seizures OR generalized tonic-clonic seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures or generalized tonic-clonic seizures, and documented use as adjunct therapy with one or more other FDA approved Anti-Epileptic Drug (AED).
Age Restrictions	12 years and greater
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: April 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Fycompa

Products Affected

- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	A diagnosis of partial-onset seizures OR generalized tonic-clonic seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures or generalized tonic-clonic seizures, and documented use as adjunct therapy with one or more other FDA approved Anti-Epileptic Drug (AED).
Age Restrictions	12 years and greater
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 TABS Per 1 DAYS
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: April 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Gabapentin

Products Affected

- *gabapentin oral capsule*

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

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Gabapentin

Products Affected

- *gabapentin 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

Gabitril

Products Affected

- GABITRIL ORAL TABLET 12 MG

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

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Gabril

Products Affected

- GABITRIL ORAL TABLET 16 MG

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

Galantamine Hydrobromide

Products Affected

- *galantamine hydrobromide*

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

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Galantamine Hydrobromide ER

Products Affected

- *galantamine hydrobromide er*

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

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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

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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

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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/inferility.html
Exclusion Criteria	
Required Medical Information	
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

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

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GaviLyte-C

Products Affected

- *gavilyte-c*

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

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GaviLyte-G

Products Affected

- *gavilyte-g*

QL Criteria	4 liters Per 1 fill
Notes/ References	
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 Vesicare and Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Gel-One

Products Affected

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

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Gelsyn-3

Products Affected

- GELSYN-3

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

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GenVisc 850

Products Affected

- GENVISC 850

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

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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

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Giazo

Products Affected

- GIAZO

PA Criteria	Criteria Details
Covered Uses	Ulcerative colitis
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild to moderate ulcerative colitis in males. Note: Per Product Labeling, Giazo effectiveness was not demonstrated in female patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of mesalamine DR (generic Asacol HD), Delzicol, Lialda, or Pentasa
QL Criteria	6 tablets Per 1 day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 capsule 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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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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Glassia

Products Affected

- GLASSIA

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

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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

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GlucaGen Diagnostic

Products Affected

- GLUCAGEN DIAGNOSTIC

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

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GlucaGen HypoKit

Products Affected

- GLUCAGEN HYPOKIT

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

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Glyxambi

Products Affected

- GLYXAMBI

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

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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/inferility.html
Exclusion Criteria	
Required Medical Information	
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

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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/inferility.html
Exclusion Criteria	
Required Medical Information	
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

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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/inferility.html
Exclusion Criteria	
Required Medical Information	
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

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Gralise

Products Affected

- GRALISE ORAL TABLET 300 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of gabapentin
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Gralise

Products Affected

- GRALISE ORAL TABLET 600 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of gabapentin
QL Criteria	3 tablets 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 starter pack Per 1 month
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Granix

Products Affected

- GRANIX

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

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GuanFACINE HCl ER

Products Affected

- *guanfacine 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	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Haegarda

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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
QL Criteria	16 kits Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Halobetasol Propionate

Products Affected

- *halobetasol propionate*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of augmented betamethasone (cream/ointment/lotion/gel)
QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Heather

Products Affected

- *heather*

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

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Helixate FS

Products Affected

- HELIXATE FS INTRAVENOUS KIT 3000 UNIT

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

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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

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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	
QL Criteria	1 capsules 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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HM Nicotine

Products Affected

- *hm nicotine*

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

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HM Nicotine Polacrilex

Products Affected

- *hm nicotine polacrilex mouth/throat lozenge*
2 mg

QL Criteria	20 EA Per 1 DAYS
Notes/ References	
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 300 MG

PA Criteria	Criteria Details
Covered Uses	Post-herpetic neuralgia and Restless leg syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Restless Leg Syndrome (RLS) or Post Herpetic Neuralgia (shingles)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR POST-HERPETIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of two weeks of gabapentin. FOR RESTLESS LEG SYNDROME: A documented contraindication, intolerance, allergy, or failure of two weeks of pramipexole or ropinirole.
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: February 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Horizant

Products Affected

- HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG

PA Criteria	Criteria Details
Covered Uses	Post-herpetic neuralgia and Restless leg syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Restless Leg Syndrome (RLS) or Post Herpetic Neuralgia (shingles)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR POST-HERPETIC NEURALGIA: A documented contraindication, intolerance, allergy, or failure of two weeks of gabapentin. FOR RESTLESS LEG SYNDROME: A documented contraindication, intolerance, allergy, or failure of two weeks of pramipexole or ropinirole.
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: February 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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HP Acthar

Products Affected

- HP ACTHAR

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

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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

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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

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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

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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

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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

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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

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HumuLIN 70/30

Products Affected

- HUMULIN 70/30

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

HumuLIN N

Products Affected

- HUMULIN N

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

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Hyalgan

Products Affected

- HYALGAN

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

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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/ANEOPPL/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

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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	

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PA Criteria	Criteria Details
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

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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	

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PA Criteria	Criteria Details
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

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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	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	

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PA Criteria	Criteria Details
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

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HYDRomorphone HCl

Products Affected

- *hydromorphone hcl oral liquid*
- *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

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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

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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

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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

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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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
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

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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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
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

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Hymovis

Products Affected

- HYMOVIS

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

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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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/ivig.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Hysingla ER

Products Affected

- HYSINGLA 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

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PA Criteria	Criteria Details
Other Criteria	
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

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Ibandronate Sodium

Products Affected

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

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

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

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

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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 EA Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Ibudone

Products Affected

- *ibudone oral tablet 5-200 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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/ANEOPPL/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/ANEOPPL/Antineoplastics.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

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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/ANEOPPL/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/ANEOPPL/Antineoplastics.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

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Idelvion

Products Affected

- IDELVION

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

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IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/I/dhifa.html
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 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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/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

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Imatinib Mesylate

Products Affected

- *imatinib mesylate oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Imatinib Mesylate

Products Affected

- *imatinib mesylate oral tablet 400 mg*

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

Products Affected

- IMBRUVICA

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

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Imitrex

Products Affected

- IMITREX NASAL SOLUTION 20
MG/ACT

QL Criteria	0.27 ml Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Imitrex

Products Affected

- IMITREX NASAL SOLUTION 5 MG/ACT

QL Criteria	0.21 ml Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imitrex STATdose System

Products Affected

- IMITREX STATDOSE SYSTEM
SUBCUTANEOUS SOLUTION AUTO-
INJECTOR 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

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Impavido

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Covered Uses	Leishmaniasis
Exclusion Criteria	Known or suspected pregnancy
Required Medical Information	A documented diagnosis of any of the following leishmaniasis infections: Visceral leishmaniasis due to <i>Leishmania donovani</i> , Cutaneous leishmaniasis due to <i>Leishmania braziliensis</i> , <i>Leishmania guyanensis</i> , and <i>Leishmania panamensis</i> , or Mucosal leishmaniasis due to <i>Leishmania braziliensis</i>
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	28 days
Other Criteria	
QL Criteria	84 capsules Per 28 days
Notes/References	
Revision Date	Prior Authorization: August 16, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Inderal XL

Products Affected

- INDERAL XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 80 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

Indomethacin

Products Affected

- *indomethacin oral*

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

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Inflectra

Products Affected

- INFLECTRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Inflectra.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Inflectra.html
Notes/References	
Revision Date	Prior Authorization: December 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Ingrezza

Products Affected

- INGREZZA ORAL CAPSULE 40 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/Ingrezza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: June 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Ingrezza

Products Affected

- INGREZZA ORAL CAPSULE 80 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/Ingrezza.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: June 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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InnoPran XL

Products Affected

- INNOPRAN XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 120 MG

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

InnoPran XL

Products Affected

- INNOPRAN XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 80 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

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Intelligence

Products Affected

- INTELENCE ORAL TABLET 100 MG, 25 MG

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

Intelligence

Products Affected

- INTELENCE ORAL TABLET 200 MG

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

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Intrarosa

Products Affected

- INTRAROSA

QL Criteria	1 insert 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

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Invokamet

Products Affected

- INVOKAMET

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

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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

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Invokana

Products Affected

- INVOKANA

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

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Ipratropium Bromide

Products Affected

- *ipratropium bromide 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

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Iprivask

Products Affected

- IPRIVASK

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

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Irbesartan

Products Affected

- *irbesartan*

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

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Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide*

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

Iressa

Products Affected

- IRESSA

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

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Isentress

Products Affected

- ISENTRESS ORAL TABLET

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

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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

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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

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Itraconazole

Products Affected

- *itraconazole oral*

QL Criteria	4 capsules 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

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Ixinity

Products Affected

- IXINITY

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

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Jadenu

Products Affected

- JADENU

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

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Jadenu Sprinkle

Products Affected

- JADENU SPRINKLE

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

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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/ANEOPPL/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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Janumet

Products Affected

- JANUMET

QL Criteria	999 tablets 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

QL Criteria	999 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Janumet XR

Products Affected

- JANUMET XR

QL Criteria	999 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Jardiance

Products Affected

- JARDIANCE

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

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Jentaduetto

Products Affected

- JENTADUETO

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

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Jentaduetto 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

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Jentaduetto 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

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Jetrea

Products Affected

- JETREA INTRAVITREAL SOLUTION
0.375 MG/0.3ML

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

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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

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Jinteli

Products Affected

- *jinteli*

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

Jolivette

Products Affected

- *jolivette*

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

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Jublia

Products Affected

- JUBLIA

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

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Juxtapid

Products Affected

- JUXTAPID

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

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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	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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Kalbitor

Products Affected

- KALBITOR

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

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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 EA 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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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 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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Kanuma

Products Affected

- KANUMA

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

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Kazano

Products Affected

- KAZANO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentadueto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
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

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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/ANEOPPL/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

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Kerydin

Products Affected

- KERYDIN

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

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

Products Affected

- *ketoconazole oral*

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

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Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine ophthalmic*

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

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Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

QL Criteria	20 tablets Per 28 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Keveyis

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2017/MISC/carb onic_anhydrase_inhibitor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kevzara

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Kevzara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Kevzara.html
QL Criteria	2 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: June 23, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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KhedeZla

Products Affected

- KHEDEZLA

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 TB24 Per 1 DAYS
Notes/References	Annual Review: 05/2017

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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

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Kisqali 200 Dose

Products Affected

- KISQALI 200 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
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 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kisqali 400 Dose

Products Affected

- KISQALI 400 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
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 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kisqali 600 Dose

Products Affected

- KISQALI 600 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
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 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kisqali Femara 200 Dose

Products Affected

- KISQALI FEMARA 200 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
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 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kisqali Femara 400 Dose

Products Affected

- KISQALI FEMARA 400 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOP/L/Kisqali.html
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 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kisqali Femara 600 Dose

Products Affected

- KISQALI FEMARA 600 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
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 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kogenate FS

Products Affected

- KOGENATE FS INTRAVENOUS KIT
3000 UNIT

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

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Kogenate FS Bio-Set

Products Affected

- KOGENATE FS BIO-SET INTRAVENOUS
KIT 3000 UNIT

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

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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 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
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

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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 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
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

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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/anti-diabetic-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 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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Kroger Blood Glucose

Products Affected

- KROGER BLOOD GLUCOSE KIT
W/DEVICE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYSS
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Kroger Premium Blood Glucose

Products Affected

- KROGER PREMIUM BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Krystexxa

Products Affected

- KRYSTEXXA

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

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Kuvan

Products Affected

- KUVAN

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

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Kynamro

Products Affected

- KYNAMRO 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/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	4 SOLN Per 30 DAYSS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LaMICtal XR

Products Affected

- LAMICTAL XR ORAL KIT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LamoTRIGine

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	2 TAB Per 1 DAILY
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LamoTRigine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	6 TAB Per 1 DAILY
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LamoTRigine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	3 TAB Per 1 DAILY
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LamoTRIGine ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LamoTRIGine ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	3 tablets Per 1 day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LamoTRIGine ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LamoTRIGine ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar I Disorder (only for ODT formulation)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of immediate release lamotrigine
QL Criteria	1 TB24 Per 1 DAYS
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lantus

Products Affected

- LANTUS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Levemir and Tresiba
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lantus SoloStar

Products Affected

- LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Levemir and Tresiba
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Larin Fe 1.5/30

Products Affected

- LARIN FE 1.5/30

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

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Latuda

Products Affected

- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
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

Latuda

Products Affected

- LATUDA ORAL TABLET 60 MG

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

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Latuda

Products Affected

- LATUDA ORAL TABLET 80 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, and clozapine
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lazanda

Products Affected

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

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

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PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
ST Criteria	<p>A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)</p>
QL Criteria	<p>15 bottles Per 1 fill</p>
Notes/References	<p>Annual Review: 06/2017</p>
Revision Date	<p>Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

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Lazanda

Products Affected

- LAZANDA NASAL SOLUTION 300 MCG/ACT

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

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PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
ST Criteria	<p>A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)</p>
QL Criteria	<p>4 bottles Per 30 days</p>
Notes/References	<p>Annual Review: 06/2017</p>
Revision Date	<p>Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

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Leflunomide

Products Affected

- *leflunomide 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

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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	6 ML Per 365 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lenvima 10 MG Daily Dose

Products Affected

- LENVIMA 10 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/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/ANEOPPL/Antineoplastics.html
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lenvima 14 MG Daily Dose

Products Affected

- LENVIMA 14 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/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/ANEOPPL/Antineoplastics.html
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lenvima 18 MG Daily Dose

Products Affected

- LENVIMA 18 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lenvima 20 MG Daily Dose

Products Affected

- LENVIMA 20 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lenvima 24 MG Daily Dose

Products Affected

- LENVIMA 24 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/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/ANEOPPL/Antineoplastics.html
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lenvima 8 MG Daily Dose

Products Affected

- LENVIMA 8 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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

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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

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LevETIRAcetam ER

Products Affected

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

LevETIRAcetam ER

Products Affected

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

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Levorphanol Tartrate

Products Affected

- *levorphanol tartrate oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Levulan Kerastick

Products Affected

- LEVULAN KERASTICK

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

Lialda

Products Affected

- LIALDA

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

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Lidocaine

Products Affected

- *lidocaine external ointment*

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

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

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Lidocaine

Products Affected

- *lidocaine external patch 5 %*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic gabapentin or Lyrica
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

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Lidocaine PAK

Products Affected

- *lidocaine pak*

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

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Lidocaine-Prilocaine

Products Affected

- *lidocaine-prilocaine external cream*

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

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PA Criteria	Criteria Details
Other Criteria	*Topical lidocaine/prilocaine cream is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Up to an additional 30 grams per 30 days. Higher additional quantities are not approvable.
QL Criteria	30 GM Per 30 Days
Notes/References	
Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lidocaine-Tetracaine

Products Affected

- *lidocaine-tetracaine*

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

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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

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

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Linzess

Products Affected

- LINZESS

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

Lipofen

Products Affected

- LIPOFEN

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

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Livalo

Products Affected

- LIVALO

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Crestor and one generic statin (atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lonsurf

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/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/ANEOPPL/Antineoplastics.html
QL Criteria	100 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Lonsurf

Products Affected

- LONSURF ORAL TABLET 20-8.19 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	80 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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

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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

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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

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Lorcet Plus

Products Affected

- LORCET PLUS ORAL TABLET 7.5-325 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	(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	

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PA Criteria	Criteria Details
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

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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

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Lovastatin

Products Affected

- *lovastatin*

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

Lucentis

Products Affected

- LUCENTIS INTRAVITREAL 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/EYE/ophtalmic_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

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Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION
0.01 %

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 one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: December 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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

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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

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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

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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

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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

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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

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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

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Lynparza

Products Affected

- LYNPARZA ORAL CAPSULE

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

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Lynparza

Products Affected

- LYNPARZA ORAL TABLET

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 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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Lyza

Products Affected

- LYZA

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

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Macugen

Products Affected

- MACUGEN

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

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Makena

Products Affected

- MAKENA

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

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Maprotiline HCl

Products Affected

- *maprotiline 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

Matzim LA

Products Affected

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

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

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Matzim LA

Products Affected

- *matzim la oral tablet extended release 24 hour 240 mg*

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

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

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Meijer Blood Glucose

Products Affected

- MEIJER BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Meijer Premium Blood Glucose

Products Affected

- MEIJER PREMIUM BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 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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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 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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Memantine HCl

Products Affected

- *memantine hcl oral tablet 10 mg, 5 mg*

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

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/inferility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/inferility.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Menostar

Products Affected

- MENOSTAR

QL Criteria	1 box (4 patches) Per 1 month
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 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

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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

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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

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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

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Mephyton

Products Affected

- MEPHYTON

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

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

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Metadate ER

Products Affected

- METADATE ER ORAL TABLET
EXTENDED RELEASE 20 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

Methadone HCl

Products Affected

- *methadone hcl oral concentrate*

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

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PA Criteria	Criteria Details
Required Medical Information	<p>(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).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information

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PA Criteria	Criteria Details
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Methadone HCl

Products Affected

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

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

PA Criteria	Criteria Details
Required Medical Information	<p>(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).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information

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PA Criteria	Criteria Details
Other Criteria	
QL Criteria	30 mg Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Methadone HCl

Products Affected

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

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

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PA Criteria	Criteria Details
Required Medical Information	<p>(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).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information

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PA Criteria	Criteria Details
Other Criteria	
QL Criteria	60 mg Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Methadone HCl

Products Affected

- *methadone hcl oral tablet*

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

PA Criteria	Criteria Details
Required Medical Information	<p>(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).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information

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PA Criteria	Criteria Details
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

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Methadone HCl Intensol

Products Affected

- *methadone hcl intensol*

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

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PA Criteria	Criteria Details
Required Medical Information	<p>(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).</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	See required medical information

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PA Criteria	Criteria Details
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Methamphetamine HCl

Products Affected

- *methamphetamine hcl*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Methergine

Products Affected

- METHERGINE 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

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Methylphenidate HCl

Products Affected

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

QL Criteria	30 milliliters 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 milliliters 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

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Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

QL Criteria	6 tablet Per 1 Day
Notes/ References	Annual Review: 10/2016
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

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Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

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

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

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Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 20 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

Methylphenidate HCl ER

Products Affected

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

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

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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

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Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

QL Criteria	1 capsule 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

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Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg*
- *methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg*

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

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Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule
extended release 24 hour 30 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule
extended release 24 hour 60 mg*

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

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Metoprolol Succinate ER

Products Affected

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

Metoprolol Succinate ER

Products Affected

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

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

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Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 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

Miacalcin

Products Affected

- MIACALCIN INJECTION

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

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Mimvey

Products Affected

- *mimvey*

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/rxnnonmedicare/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

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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

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Mitigare

Products Affected

- MITIGARE

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

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Modafinil

Products Affected

- *modafinil oral tablet 100 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 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	

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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

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Modafinil

Products Affected

- *modafinil oral tablet 200 mg*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with 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	

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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

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Mometasone Furoate

Products Affected

- *mometasone furoate external cream*
- *mometasone furoate external ointment*

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

Mononine

Products Affected

- MONONINE INTRAVENOUS SOLUTION
RECONSTITUTED 1000 UNIT

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

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Monovisc

Products Affected

- MONOVISC

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

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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

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Montelukast Sodium

Products Affected

- *montelukast sodium 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

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MorphaBond ER

Products Affected

- MORPHABOND 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

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PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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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

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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

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Morphine Sulfate

Products Affected

- *morphine sulfate oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	

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PA Criteria	Criteria Details
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

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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	

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PA Criteria	Criteria Details
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

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Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral tablet extended release 100 mg, 30 mg, 60 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
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

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Morphine Sulfate ER

Products Affected

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

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
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

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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

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PA Criteria	Criteria Details
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

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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

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Multaq

Products Affected

- MULTAQ

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

Mupirocin

Products Affected

- *mupirocin external*

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

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Mupirocin Calcium

Products Affected

- *mupirocin calcium*

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

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Myalept

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.5 VIAL Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Mydayis

Products Affected

- MYDAYIS

PA Criteria	Criteria Details
Covered Uses	Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 13 years and older
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
Age Restrictions	13 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Myobloc

Products Affected

- MYOBLOC INTRAMUSCULAR SOLUTION 2500 UNIT/0.5ML, 5000 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/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

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Myorisan

Products Affected

- *myorisan oral capsule 10 mg, 20 mg, 40 mg* • MYORISAN ORAL CAPSULE 30 MG

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 one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Mytesi

Products Affected

- MYTESI

PA Criteria	Criteria Details
Covered Uses	Non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy
Exclusion Criteria	
Required Medical Information	Covered for adult members who have a documented diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month and who are currently stable on anti-retroviral therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of at least one anti-motility agent (loperamide, diphenoxylate/atropine, bismuth subsalicylate)
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: September 12, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Myzilra

Products Affected

- *myzilra*

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

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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

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Namenda XR

Products Affected

- NAMENDA XR

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

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Namzarin

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: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Nasonex

Products Affected

- NASONEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Natpara

Products Affected

- NATPARA

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

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Nerlynx

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Nerlynx.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Nesina

Products Affected

- NESINA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
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

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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

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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

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Neupro

Products Affected

- NEUPRO

PA Criteria	Criteria Details
Covered Uses	Moderate to severe restless leg syndrome, Parkinson's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of moderate to severe restless leg syndrome or Parkinson's Disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 patch Per 1 day
Notes/References	
Revision Date	Prior Authorization: April 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Neutek 2Tek Glucose/Pressure

Products Affected

- NEUTEK 2TEK GLUCOSE/PRESSURE

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

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

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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	
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

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NexIUM

Products Affected

- NEXIUM ORAL PACKET

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic RX or OTC proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	1 pack Per 1 day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015

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NexIUM 24HR

Products Affected

- NEXIUM 24HR

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

Nexplanon

Products Affected

- NEXPLANON

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

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Next Choice One Dose

Products Affected

- *next choice one dose*

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

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Nicoderm CQ

Products Affected

- NICODERM CQ

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

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Nicorelief

Products Affected

- *nicorelief mouth/throat gum*

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicorette

Products Affected

- NICORETTE MOUTH/THROAT GUM

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Nicotine

Products Affected

- *nicotine transdermal patch 24 hour*

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

Nicotine Step 1

Products Affected

- *nicotine step 1*

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

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Nicotine Step 2

Products Affected

- *nicotine step 2*

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

Nicotine Step 3

Products Affected

- *nicotine step 3*

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

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Nicotrol

Products Affected

- NICOTROL

QL Criteria	3 boxes-504 ctrtg Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Nicotrol NS

Products Affected

- NICOTROL NS

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

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

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NIFEdipine ER

Products Affected

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

NIFEdipine ER

Products Affected

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

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

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NIFEdipine ER Osmotic Release

Products Affected

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

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Nikki

Products Affected

- NIKKI

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

Ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	3 capsules Per 28 days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 34 mg, 40 mg, 8.5 mg*

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

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hour 30 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

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Nitroglycerin

Products Affected

- *nitroglycerin translingual solution*

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

Nitrostat

Products Affected

- NITROSTAT

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

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Nityr

Products Affected

- NITYR

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

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Nora-BE

Products Affected

- *nora-be*

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

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Norditropin FlexPro

Products Affected

- NORDITROPIN FLEXPPO

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

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Norlyroc

Products Affected

- NORLYROC

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

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Northera

Products Affected

- NORTHERA ORAL CAPSULE 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 EA 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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Northera

Products Affected

- NORTHERA ORAL CAPSULE 200 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 capsules 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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Northera

Products Affected

- NORTHERA ORAL CAPSULE 300 MG

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

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NovoLIN 70/30

Products Affected

- NOVOLIN 70/30

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

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NovoLIN 70/30 ReliOn

Products Affected

- NOVOLIN 70/30 RELION

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

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NovoLIN N

Products Affected

- NOVOLIN N

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

NovoLIN N ReliOn

Products Affected

- NOVOLIN N RELION

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

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NovoLIN R

Products Affected

- NOVOLIN R

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

NovoLIN R ReliOn

Products Affected

- NOVOLIN R RELION

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

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NovoLOG

Products Affected

- NOVOLOG

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

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NovoLOG FlexPen

Products Affected

- NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

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NovoLOG Mix 70/30

Products Affected

- NOVOLOG MIX 70/30

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

NovoLOG Mix 70/30 FlexPen

Products Affected

- NOVOLOG MIX 70/30 FLEXPEN
SUBCUTANEOUS SUSPENSION PEN-
INJECTOR

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

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NovoLOG PenFill

Products Affected

- NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE

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

Noxafil

Products Affected

- NOXAFIL ORAL TABLET DELAYED RELEASE

QL Criteria	93 TBEC Per 30 DAYSS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Nucala

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/RESP/Interleukin Antagonist.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 injection Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: morphine, oxycodone, hydromorphone
QL Criteria	6 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

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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

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PA Criteria	Criteria Details
Other Criteria	
ST Criteria	FOR A DIAGNOSIS OF PAIN: A documented contraindication, intolerance, allergy, or failure of two of Butrans, Hysingla ER, or Oxycontin. FOR A DIAGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY: A documented contraindication, intolerance, allergy, or failure of Cymbalta and Lyrica.
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

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Nuedexta

Products Affected

- NUEDEXTA

QL Criteria	2 capsules 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

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Nuplazid

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/Nuplazid.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Nutropin AQ NuSpin 10

Products Affected

- NUTROPIN AQ NUSPIN 10

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

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Nutropin AQ NuSpin 20

Products Affected

- NUTROPIN AQ NUSPIN 20

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

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Nutropin AQ NuSpin 5

Products Affected

- NUTROPIN AQ NUSPIN 5

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

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NuvaRing

Products Affected

- NUVARING

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

Nuvigil

Products Affected

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

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

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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

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Nuvigil

Products Affected

- NUVIGIL ORAL TABLET 50 MG

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

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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

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Nymalize

Products Affected

- NYMALIZE ORAL SOLUTION 60
MG/20ML

QL Criteria	135.2 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Ocaliva

Products Affected

- OCALIVA ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Primary_Biliary_Cholangitis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Primary_Biliary_Cholangitis.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

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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

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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

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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

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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

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Ofev

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2017/MISC/Idiopathic_Pulmonary_Fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 EA 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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OLANZapine

Products Affected

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

Products Affected

- *olanzapine oral tablet 2.5 mg*

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

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OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl*

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

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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

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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

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Olysio

Products Affected

- OLYSIO

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

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Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

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

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Omnaris

Products Affected

- OMNARIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of two of the following: flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Omnitrope

Products Affected

- OMNITROPE

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

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OneTouch Ultra 2

Products Affected

- ONETOUCH ULTRA 2

QL Criteria	1 KIT Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OneTouch Ultra Blue

Products Affected

- ONETOUCH ULTRA BLUE

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

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OneTouch Ultra Mini

Products Affected

- ONETOUCH ULTRA MINI

QL Criteria	1 KIT Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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OneTouch Verio IQ System

Products Affected

- ONETOUCH VERIO IQ SYSTEM

QL Criteria	1 KIT Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Onfi

Products Affected

- ONFI ORAL SUSPENSION

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

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Onfi

Products Affected

- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	Seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Onglyza

Products Affected

- ONGLYZA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
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

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Onzetra Xsail

Products Affected

- ONZETRA XSAIL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of sumatriptan nasal spray
QL Criteria	1 kit Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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

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Oravig

Products Affected

- ORAVIG

QL Criteria	14 tablets 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

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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

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Orencia

Products Affected

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

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

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Orencia ClickJect

Products Affected

- ORENCIA CLICKJECT

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

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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

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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

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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 EA 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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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

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OrthoVisc

Products Affected

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

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Oseltamivir Phosphate

Products Affected

- *oseltamivir phosphate oral capsule*

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

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Oseni

Products Affected

- OSENI

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
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

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Osphena

Products Affected

- OSPHENA

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

Otezla

Products Affected

- OTEZLA ORAL TABLET

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

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Otezla

Products Affected

- OTEZLA ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Otrexup

Products Affected

- OTREXUP SUBCUTANEOUS SOLUTION
AUTO-INJECTOR 10 MG/0.4ML, 12.5
MG/0.4ML, 15 MG/0.4ML, 17.5
MG/0.4ML, 20 MG/0.4ML, 22.5
MG/0.4ML, 25 MG/0.4ML

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

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Ovidrel

Products Affected

- OVIDREL

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

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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

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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

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Oxtellar XR

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of oxcarbazepine
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

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Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 600 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of oxcarbazepine
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

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

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Oxybutynin Chloride ER

Products Affected

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

Oxybutynin Chloride ER

Products Affected

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

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

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OxyCODONE HCl

Products Affected

- *oxycodone hcl oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

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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

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OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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OxyCODONE HCl ER

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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OxyCODONE HCl ER

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent 15 mg, 30 mg, 60 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	

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PA Criteria	Criteria Details
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

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Oxycodone-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Length of Therapy; see required medical information

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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

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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	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	

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PA Criteria	Criteria Details
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

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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	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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PA Criteria	Criteria Details
Other Criteria	
QL Criteria	28 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
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

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Oxymorphone HCl

Products Affected

- *oxymorphone hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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OxyMORphone HCl ER

Products Affected

- *oxymorphone hcl er*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Paliperidone ER

Products Affected

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

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

Paliperidone ER

Products Affected

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

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

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Pancreaze

Products Affected

- PANCREAZE

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

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PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 10 mg, 20 mg*

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

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PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 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

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PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release*
24 hour 12.5 mg, 37.5 mg

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release*
24 hour 25 mg

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

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PARoxetine Mesylate

Products Affected

- *paroxetine mesylate*

QL Criteria	1 capsule 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

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Paxil

Products Affected

- PAXIL ORAL SUSPENSION

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

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PEG 3350/Electrolytes

Products Affected

- *peg 3350/electrolytes*

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

PEG-3350/Electrolytes

Products Affected

- *peg-3350/electrolytes*

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

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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

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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

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PegIntron

Products Affected

- PEGINTRON

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

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Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED
RELEASE 250 MG

QL Criteria	16 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED
RELEASE 500 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

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

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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

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Perforomist

Products Affected

- PERFOROMIST

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	4 milliliters Per 1 day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Pertzye

Products Affected

- PERTZYE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Creon and Zenpep
Notes/ References	Annual Review: 07/2017
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

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Picato

Products Affected

- PICATO EXTERNAL GEL 0.015 %

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

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Picato

Products Affected

- PICATO EXTERNAL GEL 0.05 %

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

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Pioglitazone HCl

Products Affected

- *pioglitazone hcl*

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

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Pioglitazone HCl-Glimepiride

Products Affected

- *pioglitazone hcl-glimepiride*

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

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Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-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

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Plegridy

Products Affected

- PLEGRIDY 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	28 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Plegridy

Products Affected

- PLEGRIDY 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
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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

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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/ANEOPPL/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/ANEOPPL/Antineoplastics.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

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Pradaxa

Products Affected

- PRADAXA

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

Praluent

Products Affected

- PRALUENT 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/MISC/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
QL Criteria	2 syringes 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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Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er*

QL Criteria	1 TAB Per 1 DAILY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 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

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Prasugrel HCl

Products Affected

- *prasugrel hcl*

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS) managed with percutaneous coronary intervention which includes unstable angina or non-ST elevation myocardial infarction or ST elevation myocardial infarction (MI)
Exclusion Criteria	History of Stroke or transient ischemic attack (TIA)
Required Medical Information	Member has a documented diagnosis of acute coronary syndrome (ACS) and is managed by percutaneous coronary intervention (PCI), which includes unstable angina, non-ST-elevation myocardial infarction (NSTEMI), or ST -elevation myocardial infarction (STEMI) managed with primary or delayed PCI and member has no prior history of stroke or transient ischemic attack (TIA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 22, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Pravastatin Sodium

Products Affected

- *pravastatin sodium*

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

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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

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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

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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

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Prefest

Products Affected

- PREFEST

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

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/inferility.html
Exclusion Criteria	
Required Medical Information	
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

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Premarin

Products Affected

- PREMARIN ORAL

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

Premphase

Products Affected

- PREMPHASE

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

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Prempro

Products Affected

- PREMPRO

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

Prevacid SoluTab

Products Affected

- PREVACID SOLUTAB

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic RX or OTC proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 02/2017

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Revision Date	Prior Authorization: November 21, 2016 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015
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Prezista

Products Affected

- PREZISTA ORAL SUSPENSION

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

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Prezista

Products Affected

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

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

Prezista

Products Affected

- PREZISTA ORAL TABLET 800 MG

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

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PriLOSEC OTC

Products Affected

- PRILOSEC OTC

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

Primlev

Products Affected

- PRIMLEV

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

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Pristiq

Products Affected

- PRISTIQ

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 05/2017

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

Products Affected

- PROCIT

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

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Procysbi

Products Affected

- PROCYSBI ORAL CAPSULE DELAYED
RELEASE 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
QL Criteria	8 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Procysbi

Products Affected

- PROCYSBI ORAL CAPSULE DELAYED
RELEASE 75 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
QL Criteria	25 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Prodigy AutoCode Blood Glucose

Products Affected

- PRODIGY AUTOCODE BLOOD GLUCOSE KIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYSS
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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

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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

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Promacta

Products Affected

- PROMACTA

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

Products Affected

- PROMACTA

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

Products Affected

- *propafenone hcl er*

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

Protonix

Products Affected

- PROTONIX ORAL PACKET

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic RX or OTC proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole) (not required for Nexium requests for members under one year of age)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 06, 2017 Quantity Limits: August 25, 2015

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Proventil HFA

Products Affected

- PROVENTIL HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Ventolin HFA and ProAir
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Psorcon

Products Affected

- *psorcon*

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

Pulmicort Flexhaler

Products Affected

- PULMICORT FLEXHALER

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and QVAR
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: November 30, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	2 ampules 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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Purixan

Products Affected

- PURIXAN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/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/ANEOPPL/Antineoplastics.html
QL Criteria	3.5 ML Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Qbrelis

Products Affected

- QBRELIS

PA Criteria	Criteria Details
Covered Uses	Hypertension, Heart Failure, Myocardial Infarction
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension (Approved only for ages 6 and older), Heart failure, or Myocardial Infarction AND must have a documented inability to swallow tablets/capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Qnasl

Products Affected

- QNASL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Qnasl Childrens

Products Affected

- QNASL CHILDRENS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Qudexy XR

Products Affected

- QUDEXY XR ORAL CAPSULE ER 24
HOUR SPRINKLE 100 MG, 25 MG, 50 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of the preferred generic alternative, topiramate
QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Qudexy XR

Products Affected

- QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 150 MG, 200 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of the preferred generic alternative, topiramate
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

QUetiapine Fumarate

Products Affected

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

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

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QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 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

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QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

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

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QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 300 mg, 400 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

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

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QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 300 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

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 400 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

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QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 50 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

QuilliChew ER

Products Affected

- QUILLICHEW ER ORAL TABLET
CHEWABLE EXTENDED RELEASE 20
MG, 40 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 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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QuilliChew ER

Products Affected

- QUILICHEW ER ORAL TABLET
CHEWABLE EXTENDED RELEASE 30
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 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	12 milliliters Per 1 day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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RA Nicotine

Products Affected

- *ra nicotine transdermal*

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

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Ranexa

Products Affected

- RANEXA

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

Rasagiline Mesylate

Products Affected

- *rasagiline mesylate oral*

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

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Rasuvo

Products Affected

- RASUVO SUBCUTANEOUS SOLUTION
AUTO-INJECTOR 10 MG/0.2ML, 12.5
MG/0.25ML, 15 MG/0.3ML, 17.5
MG/0.35ML, 20 MG/0.4ML, 22.5
MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML,
7.5 MG/0.15ML

ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otr
exup_Rasuvo.html">http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otr exup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ravicti

Products Affected

- RAVICTI

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

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Rayaldee

Products Affected

- RAYALDEE

PA Criteria	Criteria Details
Covered Uses	Treatment of secondary hyperparathyroidism in adult patients with stage 3 or 4 chronic kidney disease (CKD)
Exclusion Criteria	Patients with stage 5 CKD or in patients with end stage renal disease (ESRD) on dialysis
Required Medical Information	A documented diagnosis of secondary hyperparathyroidism and Stage 3 or 4 chronic kidney disease (CKD) and serum total 25-hydroxyvitamin D level is less than 30 ng/mL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of calcitriol
QL Criteria	1 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Rayos

Products Affected

- RAYOS

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

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Rebetol

Products Affected

- REBETOL ORAL SOLUTION

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

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

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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

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Rebif Rebidoose 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	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Rectiv

Products Affected

- RECTIV

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

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Regranex

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	Treatment of lower extremity diabetic neuropathic ulcers
Exclusion Criteria	Documentation that the patient has NONE of the following: Neoplasm(s) at the sites(s) of application, will not be using in pressure ulcers, venous stasis ulcers, or ischemic diabetic ulcers, exposed joints, tendons, ligaments, and bone (at application site), or will not be using in wounds that close by primary intention (such as suturing or gluing)
Required Medical Information	A documented diagnosis of diabetes with lower extremity neuropathic ulcers that extend into the subcutaneous tissue or beyond with adequate blood supply
Age Restrictions	16 years or older
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	NOTE: The safety and efficacy of treatment beyond 20 weeks have not been determined.
QL Criteria	30 grams Per 30 Days
Notes/References	
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: November 06, 2017

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Relenza Diskhaler

Products Affected

- RELENZA DISKHALER

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

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Relistor

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain and documented concomitant use of opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Relistor

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.6 ML Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Relistor

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.4 ML Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Relpax

Products Affected

- RELPAX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of three of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan
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

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

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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

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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

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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/2017/MISC/PCS_K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS_K9.html
QL Criteria	2 units Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
QL Criteria	1 syringe Per 30 days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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/2017/MISC/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
QL Criteria	2 units Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Rescula

Products Affected

- RESCULA

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 one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: December 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Retin-A Micro Pump

Products Affected

- RETIN-A MICRO PUMP EXTERNAL GEL
0.08 %

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo

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

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Products Affected

- REVATIO INTRAVENOUS

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

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Revatio

Products Affected

- REVATIO ORAL SUSPENSION
RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 capsule 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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Rexulti

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Schizophrenia
Exclusion Criteria	
Required Medical Information	Documented diagnosis of major depressive disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 08/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: October 27, 2017 Quantity Limits: August 25, 2015

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Reyataz

Products Affected

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

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

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Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 200 MG

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

Rhofade

Products Affected

- RHOFADE

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

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Riluzole

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	1 tablet 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

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Risedronate Sodium

Products Affected

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

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

Risedronate Sodium

Products Affected

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

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

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

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RisperiDONE

Products Affected

- *risperidone oral tablet 4 mg*
- *risperidone oral tablet dispersible 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

RisperiD ONE M-TAB

Products Affected

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

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RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 3 MG

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

RisperiD ONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 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

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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/rxnnonmedicare/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/rxnnonmedicare/data/2017/MUSC/Rituxan.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Rivastigmine

Products Affected

- *rivastigmine*

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

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Rivastigmine Tartrate

Products Affected

- *rivastigmine tartrate*

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

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Rixubis

Products Affected

- RIXUBIS

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

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

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

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

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

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Rozerem

Products Affected

- ROZEREM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
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

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

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Ruconest

Products Affected

- RUCONEST

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

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Rydapt

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Rydapt.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: June 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 packets 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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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 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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Saizen

Products Affected

- SAIZEN

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

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Saizen Click.Easy

Products Affected

- SAIZEN CLICK.EASY

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

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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 tablet 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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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 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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Sancuso

Products Affected

- SANCUSO

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

SandoSTATIN LAR Depot

Products Affected

- SANDOSTATIN LAR DEPOT

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

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Santyl

Products Affected

- SANTYL

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

Saphris

Products Affected

- SAPHRIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Savaysa

Products Affected

- SAVAYSA

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

Savella

Products Affected

- SAVELLA

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of fibromyalgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of duloxetine and Lyrica
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: July 18, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Savella Titration Pack

Products Affected

- SAVELLA TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of fibromyalgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of duloxetine and Lyrica
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: July 18, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Seebri Neohaler

Products Affected

- SEEBRI NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Spiriva and Incruse Ellipta
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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
- 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

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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

Sensipar

Products Affected

- SENSIPAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	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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Serevent Diskus

Products Affected

- SEREVENT DISKUS

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

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 150 MG,
200 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder, Bipolar Disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER OR SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 06/2017

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Revision Date	Prior Authorization: December 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 300 MG,
400 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder, Bipolar Disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR A DIAGNOSIS OF BIPOLAR DISORDER OR SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 06/2017

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Serostim

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

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

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Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 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

Sertraline HCl

Products Affected

- *sertraline 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

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Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 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

Sharobel

Products Affected

- SHAROBEL

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

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

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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 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Siliq

Products Affected

- SILIQ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Siliq.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Siliq.html
QL Criteria	2 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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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/MUSC/Simponi_Aria.html
QL Criteria	1 vial Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Simvastatin

Products Affected

- *simvastatin 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

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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 EA Per 365 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Sivextro

Products Affected

- SIVEXTRO ORAL

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

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Skyla

Products Affected

- SKYLA

QL Criteria	1 IUD Per 365 DAYSS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SM Nicotine

Products Affected

- *sm nicotine transdermal*

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

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Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp* • *sodium phenylbutyrate oral tablet*

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

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Solia

Products Affected

- *solia*

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

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Soliqua

Products Affected

- SOLIQUA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one of the following: Victoza, Byetta, Bydureon, Tanzeum, Trulicity, Adylixin, Lantus, Toujeo, Levemir, Tresiba, Basaglar
Notes/ References	
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

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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	
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

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Soolantra

Products Affected

- SOOLANTRA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any of the preferred topical generic alternatives, metronidazole or sulfacetamide sodium with sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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Spiriva HandiHaler

Products Affected

- SPIRIVA HANDIHALER

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

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Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT

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

Spritam

Products Affected

- SPRITAM

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

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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 tablet 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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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 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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Stelara

Products Affected

- STELARA INTRAVENOUS

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

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Stelara

Products Affected

- STELARA 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/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
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

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Stiolto Respimat

Products Affected

- STIOLTO RESPIMAT

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

Stivarga

Products Affected

- STIVARGA

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

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Strattera

Products Affected

- STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG, 60 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 100 MG,
80 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
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

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Strensiq

Products Affected

- STRENSIQ

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

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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 tablet 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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Striverdi Respimat

Products Affected

- STRIVERDI RESPIMAT

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3
MG

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

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Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG

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

Subsys

Products Affected

- SUBSYS

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

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PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
ST Criteria	<p>A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)</p>
QL Criteria	<p>120 sprays Per 30 Days</p>
Notes/References	<p>Annual Review: 06/2017</p>
Revision Date	<p>Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

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SulfaSALazine

Products Affected

- *sulfasalazine oral*

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

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Sulfazine

Products Affected

- *sulfazine*

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

SUMAtriptan

Products Affected

- *sumatriptan nasal*

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

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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

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SUMatriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution*
6 mg/0.5ml

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

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SUMatriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml*

QL Criteria	2 boxes (4 doses) Per 1 month
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 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

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SUMatriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill subcutaneous solution cartridge*

QL Criteria	2 boxes (4 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Supartz

Products Affected

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

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Supartz FX

Products Affected

- SUPARTZ FX

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

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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

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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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
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

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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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
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

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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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.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

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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/ANEOPPL/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

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Symbicort

Products Affected

- SYMBICORT

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

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	
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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Symproic

Products Affected

- SYMPROIC

PA Criteria	Criteria Details
Covered Uses	Treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain
Exclusion Criteria	Patients with known or suspected gastrointestinal obstruction or at increased risk of recurrent obstruction or with a history of a hypersensitivity reaction to naldemedine
Required Medical Information	A documented diagnosis of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain and the patient has been taking opioids for 4 weeks or more
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Movantik
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 06, 2017 Step Therapy: November 06, 2017 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

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Synalar

Products Affected

- SYNALAR EXTERNAL CREAM
- SYNALAR EXTERNAL OINTMENT

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

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Synalgos-DC

Products Affected

- SYNALGOS-DC

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

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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

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Synera

Products Affected

- SYNERA

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

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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

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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

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Synvisc

Products Affected

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

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Synvisc One

Products Affected

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

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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

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Taclonex

Products Affected

- TACLONEX EXTERNAL SUSPENSION

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

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Tacrolimus

Products Affected

- *tacrolimus external*

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis, Vitiligo
Exclusion Criteria	
Required Medical Information	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. FOR PROTOPIC 0.03%: A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required) or a documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or child 2 years of age or older and either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

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ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid (triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment)
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: October 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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/ANEOPPL/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/ANEOPPL/Antineoplastics.html
QL Criteria	4 EA 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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Tagrisso

Products Affected

- TAGRISSO

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

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Take Action

Products Affected

- *take action*

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

Taltz

Products Affected

- TALTZ

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

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Tamiflu

Products Affected

- TAMIFLU 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

Tamiflu

Products Affected

- TAMIFLU ORAL SUSPENSION
RECONSTITUTED 6 MG/ML

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

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Tanzeum

Products Affected

- TANZEUM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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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/ANEOPPL/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/ANEOPPL/Antineoplastics.html
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

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Tazarotene

Products Affected

- *tazarotene external*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris, plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Acne Vulgaris or plaque psoriasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Tazorac

Products Affected

- TAZORAC

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris, plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Acne Vulgaris or plaque psoriasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Taztia XT

Products Affected

- *taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 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

Taztia XT

Products Affected

- *taztia xt 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

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

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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 EA 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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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 EA 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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Tekturna

Products Affected

- TEKTURNA

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

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Tekturna HCT

Products Affected

- TEKTURNA HCT

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

Telmisartan

Products Affected

- *telmisartan*

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

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Telmisartan-Amlodipine

Products Affected

- *telmisartan-amlodipine*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand, Avapro, Cozaar, Micardis
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Telmisartan-HCTZ

Products Affected

- *telmisartan-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

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Temazepam

Products Affected

- *temazepam oral capsule 22.5 mg, 7.5 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

Temovate

Products Affected

- TEMOVATE EXTERNAL CREAM

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

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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/ANEOPPL/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

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Testosterone

Products Affected

- *testosterone transdermal gel 10 mg/act (2%)*

QL Criteria	4 grams 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

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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, patient will be using therapy for muscle building purposes
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing 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

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Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Testosterone

Products Affected

- *testosterone transdermal gel 25 mg/2.5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)(Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only), or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%

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QL Criteria	2.5 grams Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Testosterone

Products Affected

- *testosterone transdermal solution*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building purposes
Required Medical Information	A documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing 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 ml Per 1 day
Notes/References	

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Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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Testosterone Cypionate

Products Affected

- *testosterone cypionate intramuscular solution 100 mg/ml*

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

Testosterone Cypionate

Products Affected

- *testosterone cypionate intramuscular solution 200 mg/ml*

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

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Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg*

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

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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

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TGT Blood Glucose Monitoring

Products Affected

- TGT BLOOD GLUCOSE MONITORING

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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TGT Nicotine Step One

Products Affected

- *tgt nicotine step one*

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

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TGT Nicotine Step Three

Products Affected

- *tgt nicotine step three*

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

TGT Nicotine Step Two

Products Affected

- *tgt nicotine step two*

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

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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/ANEOPPL/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

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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

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Thrive

Products Affected

- *thrive mouth/throat gum 2 mg*

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 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

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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

Tirosint

Products Affected

- TIROSINT

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

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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

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Tivicay

Products Affected

- TIVICAY

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

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Tivorbex

Products Affected

- TIVORBEX

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

Tobi Podhaler

Products Affected

- TOBI PODHALER

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

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Tobramycin

Products Affected

- *tobramycin inhalation*

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

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

QL Criteria	999 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Toujeo SoloStar

Products Affected

- TOUJEO SOLOSTAR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Levemir and Tresiba
Notes/ References	Annual Review: 03/2016
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 Vesicare and Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Tradjenta

Products Affected

- TRADJENTA

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

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TraMADol HCl

Products Affected

- *tramadol hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
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

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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

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PA Criteria	Criteria Details
Other Criteria	
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

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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

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PA Criteria	Criteria Details
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Tranexamic Acid

Products Affected

- *tranexamic acid oral*

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

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Trelegy Ellipta

Products Affected

- TRELEGY ELLIPTA

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

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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

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Tremfya

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Tremfya.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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/Tremfya.html
QL Criteria	1 injection Per 56 days
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Tretinoin

Products Affected

- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	

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Tretinoin Microsphere

Products Affected

- *tretinoin microsphere*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	

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Tretinoin Microsphere Pump

Products Affected

- *tretinoin microsphere pump*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	

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Tretin-X

Products Affected

- TRETIN-X EXTERNAL CREAM 0.075 %

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of tretinoin and Epiduo

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Notes/ References	
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Trezix

Products Affected

- TREZIX ORAL CAPSULE 320.5-30-16 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

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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

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Tribenzor

Products Affected

- TRIBENZOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand HCT, Avalide, Hyzaar, Micardis HCT
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trintellix

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 Day
Notes/References	

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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

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Triumeq

Products Affected

- TRIUMEQ

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

Trokendi XR

Products Affected

- TROKENDI XR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Topamax
QL Criteria	1 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Trospium Chloride

Products Affected

- *trospium chloride*

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

Trospium Chloride ER

Products Affected

- *trospium chloride er*

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

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TRUEresult Blood Glucose

Products Affected

- TRUERESULT BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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TrueTrack Blood Glucose

Products Affected

- TRUETRACK BLOOD GLUCOSE KIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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TrueTrack Smart System

Products Affected

- TRUETRACK SMART SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Trulicity

Products Affected

- TRULICITY

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Tudorza Pressair

Products Affected

- TUDORZA PRESSAIR INHALATION
AEROSOL POWDER BREATH
ACTIVATED

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Spiriva and Incruse Ellipta
QL Criteria	1 inhaler Per 30 fills
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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TussiCaps

Products Affected

- TUSSICAPS

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

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Tybost

Products Affected

- TYBOST

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

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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	
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

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Tymlos

Products Affected

- TYMLOS

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

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Tysabri

Products Affected

- TYSABRI

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

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Tyvaso

Products Affected

- TYVASO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	1 SOLN Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Tyvaso Refill

Products Affected

- TYVASO REFILL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Tyvaso Starter

Products Affected

- TYVASO STARTER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Uceris

Products Affected

- UCERIS ORAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Asacol HD, Delzicol, Lialda or Pentasa
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uceris

Products Affected

- UCERIS RECTAL

PA Criteria	Criteria Details
Covered Uses	Active mild to moderate ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of ACTIVE mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge, requiring induction of remission.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 canisters Per 1 month
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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Ultravate

Products Affected

- ULTRAVATE EXTERNAL LOTION

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

Uptravi

Products Affected

- UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG

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

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Uptravi

Products Affected

- UPTRAVI ORAL TABLET 200 MCG PACK
- UPTRAVI ORAL TABLET THERAPY

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

Utibron Neohaler

Products Affected

- UTIBRON NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Anoro Ellipta and Stiolto
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Valchlor

Products Affected

- VALCHLOR

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

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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	
QL Criteria	1000 ML Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: November 13, 2017

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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 TABS Per 30 DAYSS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

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Vantas

Products Affected

- VANTAS

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

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Varubi

Products Affected

- VARUBI ORAL

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

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Vascepa

Products Affected

- VASCEPA ORAL CAPSULE 0.5 GM

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

Vascepa

Products Affected

- VASCEPA ORAL CAPSULE 1 GM

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

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Vecamyl

Products Affected

- VECAMYL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CV/antihypertensive_misc.html
QL Criteria	10 tabs 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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Veletri

Products Affected

- VELETRI

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

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Veltassa

Products Affected

- VELTASSA

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

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Veltin

Products Affected

- VELTIN

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

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Vemlidy

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Vemlidy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Vemlidy.html
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 10 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	40 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 50 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Venclexta Starting Pack

Products Affected

- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 pack Per 28 days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 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

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Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

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

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Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

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

Venlafaxine HCl ER

Products Affected

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

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Venlafaxine HCl ER

Products Affected

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

Venlafaxine HCl ER

Products Affected

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

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

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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

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Verapamil HCl ER

Products Affected

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

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

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Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

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

Verdrocet

Products Affected

- VERDROCET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Versacloz

Products Affected

- VERSACLOZ

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

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Verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Verzenio.html
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: November 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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VESicare

Products Affected

- VESICARE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Viberzi

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Covered Uses	Diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	No known or suspected history of any of the following: does not have a gallbladder, diagnosis of pancreatitis, diagnosis of alcoholism, member drinks more than 3 alcoholic beverages/day, severe (Child-Pugh C) hepatic impairment, or anatomic or biochemical abnormalities of the gastrointestinal tract (e.g., biliary duct obstruction, sphincter of Oddi dysfunction, or severe constipation)
Required Medical Information	A documented diagnosis of diarrhea-predominant irritable bowel syndrome (IBS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Vicodin

Products Affected

- *vicodin oral tablet 5-300 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	<p>(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.</p>
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	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Victoza

Products Affected

- VICTOZA SUBCUTANEOUS SOLUTION
PEN-INJECTOR

QL Criteria	1 box-2 or 3 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

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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
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

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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

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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

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Viibryd

Products Affected

- VIIBRYD ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 05/2017

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Viibryd

Products Affected

- VIIBRYD ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Diagnosis of major depressive disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 05/2017
Revision Date	Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Viibryd Starter Pack

Products Affected

- VIIBRYD STARTER PACK

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major Depressive Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For quantities over the allowed amount for the prescribed medication, a member must meet one of the following: (1) Member requires a dose including half tablets, (2) member's dose is being titrated by physician (3-month limit), (3) member has had intolerance to drug administered as a single daily dose, or (4) member's dose cannot be achieved with proposed quantity limits for a given strength (ex. needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 3 different antidepressants from at least two different therapeutic subclasses. Examples include SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), and heterocyclic antidepressants (mirtazapine, trazodone).
Notes/References	Annual Review: 05/2017

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Vimizim

Products Affected

- VIMIZIM

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

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Vimpat

Products Affected

- VIMPAT ORAL SOLUTION

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

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Vimpat

Products Affected

- VIMPAT 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

Viokace

Products Affected

- VIOKACE

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

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Viorele

Products Affected

- *viorele*

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

Viread

Products Affected

- VIREAD ORAL TABLET

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

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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

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Vivlodex

Products Affected

- VIVLODEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two generic non steroidal anti-inflammatory drugs
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Voltaren

Products Affected

- VOLTAREN TRANSDERMAL

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

Vonvendi

Products Affected

- VONVENDI

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

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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

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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 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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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

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Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 1.5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
QL Criteria	4 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 3 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
QL Criteria	2 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE THERAPY PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vytorin

Products Affected

- VYTORIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic simvastatin in combination with generic ezetimibe, or generic ezetimibe-simvastatin
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Vyvanse

Products Affected

- VYVANSE

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

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Vyvanse

Products Affected

- VYVANSE

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

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Xadago

Products Affected

- XADAGO

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease (PD) experiencing "off" episodes
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Parkinson's disease and concurrent use of levodopa/carbidopa
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of rasagaline or selegiline
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: June 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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/ANEOPPL/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

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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

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

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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

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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

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Xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Xermelo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 200 MG

QL Criteria	9 tablets Per 1 fill
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea.
Exclusion Criteria	
Required Medical Information	FOR HEPATIC ENCEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED
RELEASE 24 HOUR 10-1000 MG, 10-500
MG, 5-500 MG

QL Criteria	1 TAB Per 1 DAYS
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

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Xolair

Products Affected

- XOLAIR

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

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Xopenex HFA

Products Affected

- XOPENEX HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Ventolin HFA and ProAir
QL Criteria	2 inhalers Per 1 fill
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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

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PA Criteria	Criteria Details
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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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/ANEOPPL/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/ANEOPPL/Antineoplastics.html
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

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Xulane

Products Affected

- XULANE

QL Criteria	1 box (3 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Xultophy

Products Affected

- XULTOPHY

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one of the following: Victoza, Byetta, Bydureon, Tanzeum, Trulicity, Adylixin, Lantus, Toujeo, Levemir, Tresiba, Basaglar
QL Criteria	5 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xuriden

Products Affected

- XURIDEN

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

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Xylon

Products Affected

- XYLON

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 09, 2017

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

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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

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Zafirlukast

Products Affected

- *zafirlukast*

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

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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

Zaltrap

Products Affected

- ZALTRAP

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

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Zarxio

Products Affected

- ZARXIO

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

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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	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Zegerid OTC

Products Affected

- ZEGERID OTC

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

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Zejula

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Zejula.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 09, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
QL Criteria	8 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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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

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Zembrace SymTouch

Products Affected

- ZEMBRACE SYMTOUCH

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic Imitrex injection
QL Criteria	8 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenatane

Products Affected

- *zenatane oral capsule 10 mg, 20 mg, 40 mg*

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

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Zenatane

Products Affected

- ZENATANE ORAL CAPSULE 30 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

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Zenzedi

Products Affected

- ZENZEDI ORAL TABLET 10 MG, 5 MG

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

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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

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Zetia

Products Affected

- ZETIA

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

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Zetonna

Products Affected

- ZETONNA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
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 Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Zileuton ER

Products Affected

- *zileuton er*

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

Zinbryta

Products Affected

- ZINBRYTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 injection Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Zioptan

Products Affected

- ZIOPTAN

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 one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: December 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Ziprasidone HCl

Products Affected

- *ziprasidone hcl*

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

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Zohydro ER

Products Affected

- ZOHYDRO ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(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.</p>
Age Restrictions	
Prescriber Restrictions	

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PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
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

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Zoladex

Products Affected

- ZOLADEX

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

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Zoledronic Acid

Products Affected

- *zoledronic acid intravenous concentrate*
- *zoledronic acid intravenous solution*

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

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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	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
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

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ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 2.5 mg*

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

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ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 5 mg*

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

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ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet dispersible 2.5 mg*

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

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ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet dispersible 5 mg*

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

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate oral*

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

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Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Zomig

Products Affected

- ZOMIG NASAL SOLUTION 5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of three of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan
QL Criteria	1 box (6 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 tablet 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

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Zorbtive

Products Affected

- ZORBTIVE

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

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Zorvolex

Products Affected

- ZORVOLEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic non steroidal anti-inflammatory drug (NSAID)
QL Criteria	3 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET
SUBLINGUAL 0.7-0.18 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
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

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Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET
SUBLINGUAL 1.4-0.36 MG, 11.4-2.9 MG,
2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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Zurampic

Products Affected

- ZURAMPIC

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperuricemia associated with gout
Exclusion Criteria	
Required Medical Information	A documented diagnosis of gout, and will be used in combination with a xanthine oxidase inhibitor (allopurinol OR febuxostat)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of allopurinol or febuxostat
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 04, 2017 Quantity Limits: August 25, 2015

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Zyban

Products Affected

- ZYBAN

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

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

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Zyflo

Products Affected

- ZYFLO

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

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Zyflo CR

Products Affected

- ZYFLO CR

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

Zykadia

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/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/ANEOPPL/Antineoplastics.html
QL Criteria	5 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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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 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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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/ANEOPPL/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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