# 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** | 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 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: October 10, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Acamprosate Calcium

**Products Affected**

- *acamprosate calcium*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Acetaminophen-Codeine

**Products Affected**

- *acetaminophen-codeine oral solution*

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Acetaminophen-Codeine

**Products Affected**

- *acetaminophen-codeine oral tablet*

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

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

# Acetaminophen-Codeine #2

**Products Affected**

- *acetaminophen-codeine #2*

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

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

# Acetaminophen-Codeine #3

**Products Affected**

- *acetaminophen-codeine #3*

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

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

# Acetaminophen-Codeine #4

**Products Affected**

- *acetaminophen-codeine #4*

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

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

# AcipHex Sprinkle

**Products Affected**

- ACIPHEX SPRINKLE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). In addition for approval the following criteria must also be met: Documentation of an inability to swallow tablets/capsules. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | 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 |

2017 Aetna Pharmacy Drug Guide - Five Tier Open Value Small Group Formulary
Last Update 12/2017
Next Update

| | |
|---|---|
| **Revision Date** | Prior Authorization: November 21, 2016<br>Step Therapy: October 06, 2017<br>Quantity Limits: August 25, 2015 |

# Acitretin

**Products Affected**

- *acitretin*

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

# Actemra

**Products Affected**

- ACTEMRA SUBCUTANEOUS

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

# Actimmune

**Products Affected**

- ACTIMMUNE

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

# Actoplus met XR

**Products Affected**

- ACTOPLUS MET XR

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: November 06, 2017<br>Quantity Limits: August 25, 2015 |

# Adagen

**Products Affected**

- ADAGEN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Adcirca

**Products Affected**

- ADCIRCA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Adefovir Dipivoxil

**Products Affected**

- *adefovir dipivoxil*

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

# Adempas

**Products Affected**

- ADEMPAS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **QL Criteria** | 3 TABS Per 1 DAYS |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Advair HFA

**Products Affected**

- ADVAIR HFA

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

# Advocate Duo

**Products Affected**

- ADVOCATE DUO DEVICE

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

# Adyphren

**Products Affected**

- ADYPHREN

| | |
|---|---|
| **QL Criteria** | 4 injections Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Adyphren II

**Products Affected**

- ADYPHREN II

| | |
|---|---|
| **QL Criteria** | 4 injections Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Aerospan

**Products Affected**

- AEROSPAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Asthma |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of Asthma |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Afinitor

**Products Affected**

- AFINITOR

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

# Afinitor Disperz

**Products Affected**

- AFINITOR DISPERZ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Afstyla

**Products Affected**

- AFSTYLA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Akynzeo

**Products Affected**

- AKYNZEO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Prophylaxis of chemotherapy-induced nausea and vomiting |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of nausea and vomiting associated with cancer chemotherapy |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Akynzeo will be considered medically necessary for those members who have 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Alecensa

**Products Affected**

- ALECENSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Alinia

**Products Affected**

- ALINIA ORAL SUSPENSION RECONSTITUTED

| | |
|---|---|
| **QL Criteria** | 60 ml Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Almotriptan Malate

**Products Affected**

- *almotriptan malate*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Alogliptin-Metformin HCl

**Products Affected**

- *alogliptin-metformin hcl*

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Alosetron HCl

**Products Affected**

- *alosetron 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ALPRAZolam ER

**Products Affected**

- *alprazolam er*

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

# ALPRAZolam XR

**Products Affected**

- *alprazolam xr*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Alvesco

**Products Affected**

- ALVESCO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Asthma |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of Asthma |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Amcinonide

**Products Affected**

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

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

# Amlodipine Besylate-Valsartan

**Products Affected**

- *amlodipine besylate-valsartan*

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

# Amlodipine-Olmesartan

**Products Affected**

- *amlodipine-olmesartan*

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

# Amlodipine-Valsartan-HCTZ

**Products Affected**

- *amlodipine-valsartan-hctz*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Amphetamine-Dextroamphetamine

**Products Affected**

- *amphetamine-dextroamphetamine*

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

# Ampyra

**Products Affected**

- AMPYRA

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Anoro Ellipta

**Products Affected**

- ANORO ELLIPTA

| | |
|---|---|
| **QL Criteria** | 60 BLISTERS Per 30 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Antara

**Products Affected**

- ANTARA ORAL CAPSULE 30 MG, 90 MG

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

# APAP-Caff-Dihydrocodeine

**Products Affected**

- *apap-caff-dihydrocodeine oral capsule*

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Apidra SoloStar

**Products Affected**

- APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# Aprepitant

**Products Affected**

- *aprepitant oral capsule 80 & 125 mg*

| | |
|---|---|
| **QL Criteria** | 9 capsules Per 30 days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Aralast NP

**Products Affected**

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG

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

# Aranesp (Albumin Free)

**Products Affected**

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

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

# Arcalyst

**Products Affected**

- ARCALYST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Arcapta Neohaler

**Products Affected**

- ARCAPTA NEOHALER

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

# ARIPiprazole

**Products Affected**

- *aripiprazole oral solution*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Armodafinil

**Products Affected**

- *armodafinil oral tablet 50 mg*

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

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| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: June 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Arzerra

**Products Affected**

- ARZERRA

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ascomp-Codeine

**Products Affected**

- *ascomp-codeine*

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Atorvastatin Calcium

**Products Affected**

- *atorvastatin calcium oral*

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

# Atripla

**Products Affected**

- ATRIPLA

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

# Atrovent HFA

**Products Affected**

- ATROVENT HFA

| | |
|---|---|
| **QL Criteria** | 2 inhalers Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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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| | |
|---|---|
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 |

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

# Avonex

**Products Affected**

- AVONEX

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

# Avonex Pen

**Products Affected**

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT

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

# Avonex Prefilled

**Products Affected**

- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

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

# Azilect

**Products Affected**

- AZILECT

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Balsalazide Disodium

**Products Affected**

- *balsalazide disodium*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 2 films Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Benlysta

**Products Affected**

- BENLYSTA INTRAVENOUS

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

# Benlysta

**Products Affected**

- BENLYSTA SUBCUTANEOUS

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

# Berinert

**Products Affected**

- BERINERT

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Betamethasone Dipropionate Aug

**Products Affected**

- *betamethasone dipropionate aug external lotion*

| | |
|---|---|
| **QL Criteria** | 120 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Betamethasone Valerate

**Products Affected**

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

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

# Betaseron

**Products Affected**

- BETASERON SUBCUTANEOUS KIT

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

# Bethkis

**Products Affected**

- BETHKIS

| | |
|---|---|
| **QL Criteria** | 56 ampules Per 30 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Bevespi Aerosphere

**Products Affected**

- BEVESPI AEROSPHERE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Chronic Obstructive Pulmonary Disorder (COPD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: October 05, 2017<br>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/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Bicalutamide

**Products Affected**

- *bicalutamide*

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

# Bimatoprost

**Products Affected**

- *bimatoprost ophthalmic*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | open-angle glaucoma, ocular hypertension |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of glaucoma or ocular hypertension |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: December 07, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Bosulif

**Products Affected**

- BOSULIF ORAL TABLET 100 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 4 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Bosulif

**Products Affected**

- BOSULIF ORAL TABLET 500 MG

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

# Botox

**Products Affected**

- BOTOX

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Bravelle

**Products Affected**

- BRAVELLE

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Brilinta

**Products Affected**

- BRILINTA

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

# Briviact

**Products Affected**

- BRIVIACT ORAL SOLUTION

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

# Briviact

**Products Affected**

- BRIVIACT ORAL TABLET

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

# Brovana

**Products Affected**

- BROVANA

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

# Budesonide

**Products Affected**

- *budesonide inhalation*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Asthma |
| **Exclusion Criteria** | |
| **Required Medical Information** | For ages 5-8 documented inability to use metered dose inhalers |
| **Age Restrictions** | Less than 8 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | No prior authorization required for children 1-4 years of age. Medical Exception allowed for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory and for Nasal Polyps when all criteria met: A diagnosis of chronic sinusitis with nasal polyposis, endoscopic sinus surgery has been performed, and standard nasal steroid sprays have been used as part of post-operative management and have failed. |
| **QL Criteria** | 4 ML Per 1 Day |
| **Notes/ References** | Annual Review: 07/2017 |
| **Revision Date** | Prior Authorization: January 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Bunavail

**Products Affected**

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Buprenorphine

**Products Affected**

- *buprenorphine*

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 4 patches Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Buprenorphine HCl

**Products Affected**

- *buprenorphine hcl sublingual*

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

# BuPROPion HCl

**Products Affected**

- *bupropion hcl oral*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Butalbital-APAP-Caff-Cod

**Products Affected**

- *butalbital-apap-caff-cod*

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

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

# Butalbital-ASA-Caff-Codeine

**Products Affected**

- *butalbital-asa-caff-codeine*

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

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

# Butorphanol Tartrate

**Products Affected**

- *butorphanol tartrate nasal*

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

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

# 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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Next Update

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 4 patches Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cabometyx

**Products Affected**

- CABOMETYX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Canasa

**Products Affected**

- CANASA

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

# Candesartan Cilexetil-HCTZ

**Products Affected**

- *candesartan cilexetil-hctz*

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

# Capecitabine

**Products Affected**

- *capecitabine*

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

# Caprelsa

**Products Affected**

- CAPRELSA ORAL TABLET 100 MG

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

# Caprelsa

**Products Affected**

- CAPRELSA ORAL TABLET 300 MG

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

# Carbaglu

**Products Affected**

- CARBAGLU

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cardura XL

**Products Affected**

- CARDURA XL

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Celecoxib

**Products Affected**

- *celecoxib oral*

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

# Cerezyme

**Products Affected**

- CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cesamet

**Products Affected**

- CESAMET

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

# Cetrotide

**Products Affected**

- CETROTIDE SUBCUTANEOUS KIT 0.25 MG

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

# Cevimeline HCl

**Products Affected**

- *cevimeline hcl*

| | |
|---|---|
| **QL Criteria** | 3 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Chantix

**Products Affected**

- CHANTIX

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

# Chantix Starting Month Pak

**Products Affected**

- CHANTIX STARTING MONTH PAK

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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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| | |
|---|---|
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cholbam

**Products Affected**

- CHOLBAM

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

# Chorionic Gonadotropin

**Products Affected**

- *chorionic gonadotropin intramuscular*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ciclodan

**Products Affected**

- CICLODAN EXTERNAL SOLUTION

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

# Ciclopirox

**Products Affected**

- *ciclopirox external solution*

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

# Cimzia

**Products Affected**

- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Cimzia.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Cimzia.html |
| **QL Criteria** | 1 kit Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cimzia Prefilled

**Products Affected**

- CIMZIA PREFILLED

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Cimzia.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Cimzia.html |
| **QL Criteria** | 1 kit Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cimzia Starter Kit

**Products Affected**

- CIMZIA STARTER KIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Cimzia.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Cimzia.html |
| **QL Criteria** | 1 kit Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cinqair

**Products Affected**

- CINQAIR

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

# Cinryze

**Products Affected**

- CINRYZE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Claravis

**Products Affected**

- *claravis*

| | |
|---|---|
| **QL Criteria** | 2 Capsules Per 1 Day |
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Clarinex-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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Climara Pro

**Products Affected**

- CLIMARA PRO

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Clobetasol Propionate

**Products Affected**

- *clobetasol propionate external foam*

| | |
|---|---|
| **QL Criteria** | 100 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Clobetasol Propionate

**Products Affected**

- *clobetasol propionate external lotion*

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

# Clobetasol Propionate

**Products Affected**

- *clobetasol propionate external solution*

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

# Clobetasol Propionate E

**Products Affected**

- *clobetasol propionate e*

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

# Clobetasol Propionate Emulsion

**Products Affected**

- *clobetasol propionate emulsion*

| | |
|---|---|
| **QL Criteria** | 100 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Clodan

**Products Affected**

- *clodan external shampoo*

| | |
|---|---|
| **QL Criteria** | 236 ML Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Clopidogrel Bisulfate

**Products Affected**

- *clopidogrel bisulfate oral*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# CloZAPine

**Products Affected**

- *clozapine oral tablet dispersible 150 mg*

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

# Coagadex

**Products Affected**

- COAGADEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Codeine Sulfate

**Products Affected**

- *codeine sulfate oral tablet*

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

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

# Colchicine

**Products Affected**

- *colchicine oral*

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

# CombiPatch

**Products Affected**

- COMBIPATCH

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

# Cometriq (100 mg Daily Dose)

**Products Affected**

- COMETRIQ (100 MG DAILY DOSE)

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

# Cometriq (140 mg Daily Dose)

**Products Affected**

- COMETRIQ (140 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 caupsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cometriq (60 mg Daily Dose)

**Products Affected**

- COMETRIQ (60 MG DAILY DOSE)

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

# Complera

**Products Affected**

- COMPLERA

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

# Copaxone

**Products Affected**

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML

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

# Cordran

**Products Affected**

- CORDRAN EXTERNAL TAPE

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

# Coreg CR

**Products Affected**

- COREG CR

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of carvedilol |
| **QL Criteria** | 1 capsule Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Corlanor

**Products Affected**

- CORLANOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | FDA labeled use for heart failure |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, and who are on maximally tolerated doses of beta-blockers (bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate/metoprolol succinate-HCTZ, nevibolol) or have a documented contraindication to beta-blocker use. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of one month of 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cotellic

**Products Affected**

- COTELLIC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cuprimine

**Products Affected**

- CUPRIMINE ORAL CAPSULE 250 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cycloset

**Products Affected**

- CYCLOSET

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

# Cystagon

**Products Affected**

- CYSTAGON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cystaran

**Products Affected**

- CYSTARAN

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

# Daklinza

**Products Affected**

- DAKLINZA

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

# Daklinza

**Products Affected**

- DAKLINZA

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dapsone

**Products Affected**

- *dapsone external*

| | |
|---|---|
| **QL Criteria** | 60 grams Per 30 dayss |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Darifenacin Hydrobromide ER

**Products Affected**

- *darifenacin hydrobromide er*

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

# Daytrana

**Products Affected**

- DAYTRANA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Attention deficit hyperactivity disorder (ADHD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) |
| **Age Restrictions** | For Quillivant Only- 17 years of age and older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Delzicol

**Products Affected**

- DELZICOL

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

# Descovy

**Products Affected**

- DESCOVY

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

# Desloratadine

**Products Affected**

- *desloratadine*

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

# Desonide

**Products Affected**

- *desonide external*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>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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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dexilant

**Products Affected**

- DEXILANT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | 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<br>Step Therapy: October 06, 2017<br>Quantity Limits: August 25, 2015 |

# Dexmethylphenidate HCl

**Products Affected**

- *dexmethylphenidate hcl*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dextroamphetamine Sulfate ER

**Products Affected**

- *dextroamphetamine sulfate er*

| | |
|---|---|
| **QL Criteria** | 4 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Diclofenac Sodium

**Products Affected**

- *diclofenac sodium transdermal gel 1 %*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dificid

**Products Affected**

- DIFICID

| | |
|---|---|
| **QL Criteria** | 20 tablets Per 1 fill |
| **Notes/ References** | Annual Review: 09/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Diltiazem CD

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Diltiazem HCl ER Beads

**Products Affected**

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

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

# DilTIAZem HCl ER Coated Beads

**Products Affected**

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

| | |
|---|---|
| **QL Criteria** | 2 Capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Doxepin HCl

**Products Affected**

- *doxepin hcl external*

| | |
|---|---|
| **QL Criteria** | 45 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Doxercalciferol

**Products Affected**

- *doxercalciferol oral*

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

# Duavee

**Products Affected**

- DUAVEE

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dutasteride

**Products Affected**

- *dutasteride*

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

# 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<br>Step Therapy: October 04, 2017<br>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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dysport

**Products Affected**

- DYSPORT

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Econazole Nitrate

**Products Affected**

- *econazole nitrate external*

| | |
|---|---|
| **QL Criteria** | 85 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Edarbi

**Products Affected**

- EDARBI

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

# Edurant

**Products Affected**

- EDURANT

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

# Elelyso

**Products Affected**

- ELELYSO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Elestrin

**Products Affected**

- ELESTRIN

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Elmiron

**Products Affected**

- ELMIRON

| | |
|---|---|
| **QL Criteria** | 90 capsules Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Emsam

**Products Affected**

- EMSAM

| | |
|---|---|
| **QL Criteria** | 1 patch Per 1 day |
| **Notes/ References** | Annual Review: 09/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Emverm

**Products Affected**

- EMVERM

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

# Enbrel SureClick

**Products Affected**

- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html |
| **QL Criteria** | 8 syringes Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Enoxaparin Sodium

**Products Affected**

- *enoxaparin sodium*

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

# Entecavir

**Products Affected**

- *entecavir*

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

# Entresto

**Products Affected**

- ENTRESTO

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

# Entyvio

**Products Affected**

- ENTYVIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# EPINEPHrine

**Products Affected**

- *epinephrine injection solution auto-injector*

| | |
|---|---|
| **QL Criteria** | 4 injections Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Epogen

**Products Affected**

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

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

# Epoprostenol Sodium

**Products Affected**

- *epoprostenol sodium*

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

# Eprosartan Mesylate

**Products Affected**

- *eprosartan mesylate*

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

# Erivedge

**Products Affected**

- ERIVEDGE

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

# Esbriet

**Products Affected**

- ESBRIET ORAL CAPSULE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Esbriet

**Products Affected**

- ESBRIET ORAL TABLET 267 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Esbriet

**Products Affected**

- ESBRIET ORAL TABLET 801 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Escitalopram Oxalate

**Products Affected**

- *escitalopram oxalate oral solution*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Estradiol

**Products Affected**

- *estradiol transdermal patch twice weekly*

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

# Estradiol-Norethindrone Acet

**Products Affected**

- *estradiol-norethindrone acet*

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

# Eszopiclone

**Products Affected**

- *eszopiclone*

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

# Evamist

**Products Affected**

- EVAMIST

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Extavia

**Products Affected**

- EXTAVIA SUBCUTANEOUS KIT

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

# Ezetimibe

**Products Affected**

- *ezetimibe*

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

# Ezetimibe-Simvastatin

**Products Affected**

- *ezetimibe-simvastatin*

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

# Fabrazyme

**Products Affected**

- FABRAZYME

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Famciclovir

**Products Affected**

- *famciclovir oral tablet 500 mg*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Farxiga

**Products Affected**

- FARXIGA

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 12 EA Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Faslodex

**Products Affected**

- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML

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

# Felodipine ER

**Products Affected**

- *felodipine er*

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

# Femring

**Products Affected**

- FEMRING

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

# Fenofibrate

**Products Affected**

- *fenofibrate oral capsule*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fenofibric Acid

**Products Affected**

- *fenofibric acid oral tablet*

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

# FentaNYL

**Products Affected**

- *fentanyl*

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# FentaNYL Citrate

**Products Affected**

- *fentanyl citrate buccal*

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

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

# 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** | |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ferriprox

**Products Affected**

- FERRIPROX

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

# 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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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fetzima Titration

**Products Affected**

- FETZIMA TITRATION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Major depressive disorder |
| **Exclusion Criteria** | |
| **Required Medical Information** | 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 |

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

| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fibricor

**Products Affected**

- FIBRICOR

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

# 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** | |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Firmagon

**Products Affected**

- FIRMAGON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Flebogamma DIF

**Products Affected**

- FLEBOGAMMA DIF

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

# Flolan

**Products Affected**

- FLOLAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Flovent Diskus

**Products Affected**

- FLOVENT DISKUS

| | |
|---|---|
| **QL Criteria** | 2 blisters Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Flovent HFA

**Products Affected**

- FLOVENT HFA

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

# Fluocinolone Acetonide

**Products Affected**

- *fluocinolone acetonide external cream*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fluocinonide

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fluticasone-Salmeterol

**Products Affected**

- *fluticasone-salmeterol*

| | |
|---|---|
| **QL Criteria** | 1 inhaler Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fluvastatin Sodium

**Products Affected**

- *fluvastatin sodium*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# FluvoxaMINE Maleate ER

**Products Affected**

- *fluvoxamine maleate er*

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

# Focalin XR

**Products Affected**

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

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Follistim AQ

**Products Affected**

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

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

# Fondaparinux Sodium

**Products Affected**

- *fondaparinux sodium*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fragmin

**Products Affected**

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

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

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# FreeStyle InsuLinx Test

**Products Affected**

- FREESTYLE INSULINX TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# FreeStyle Lite Test

**Products Affected**

- FREESTYLE LITE TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# FreeStyle Test

**Products Affected**

- FREESTYLE TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Frovatriptan Succinate

**Products Affected**

- *frovatriptan succinate*

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

# Fuzeon

**Products Affected**

- FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gabapentin

**Products Affected**

- *gabapentin oral capsule*

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

# Gabapentin

**Products Affected**

- *gabapentin oral tablet*

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

# Gabitril

**Products Affected**

- GABITRIL ORAL TABLET 16 MG

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gammaplex

**Products Affected**

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

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

# Gamunex-C

**Products Affected**

- GAMUNEX-C

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

# Ganirelix Acetate

**Products Affected**

- *ganirelix acetate*

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

# Gattex

**Products Affected**

- GATTEX

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

# GaviLyte-C

**Products Affected**

- *gavilyte-c*

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

# GaviLyte-G

**Products Affected**

- *gavilyte-g*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gelsyn-3

**Products Affected**

- GELSYN-3

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Genvoya

**Products Affected**

- GENVOYA

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

# Giazo

**Products Affected**

- GIAZO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Ulcerative colitis |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of mild to moderate ulcerative colitis in males. Note: Per Product Labeling, Giazo effectiveness was not demonstrated in female patients. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | Step Therapy |
| **ST Criteria** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gilenya

**Products Affected**

- GILENYA

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

# Gilotrif

**Products Affected**

- GILOTRIF

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Glatopa

**Products Affected**

- *glatopa*

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

# GlucaGen Diagnostic

**Products Affected**

- GLUCAGEN DIAGNOSTIC

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

# GlucaGen HypoKit

**Products Affected**

- GLUCAGEN HYPOKIT

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gonal-f

**Products Affected**

- GONAL-F

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

# Gonal-f RFF

**Products Affected**

- GONAL-F RFF

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

# Gonal-f RFF Rediject

**Products Affected**

- GONAL-F RFF REDIJECT

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

# Gralise

**Products Affected**

- GRALISE ORAL TABLET 300 MG

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

# Gralise

**Products Affected**

- GRALISE ORAL TABLET 600 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of gabapentin |
| **QL Criteria** | 3 tablets Per 1 day |
| **Notes/ References** | Annual Review: 02/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Granix

**Products Affected**

- GRANIX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Haegarda

**Products Affected**

- HAEGARDA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Harvoni

**Products Affected**

- HARVONI

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

# Heather

**Products Affected**

- *heather*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Hemangeol

**Products Affected**

- HEMANGEOL

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

# Hetlioz

**Products Affected**

- HETLIOZ

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

# HM Nicotine

**Products Affected**

- *hm nicotine*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# HP Acthar

**Products Affected**

- HP ACTHAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Humira

**Products Affected**

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

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

# Humira Pen-Crohns Starter

**Products Affected**

- HUMIRA PEN-CROHNS STARTER SUBCUTANEOUS PEN-INJECTOR KIT

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

# Humira Pen-Psoriasis Starter

**Products Affected**

- HUMIRA PEN-PSORIASIS STARTER SUBCUTANEOUS PEN-INJECTOR KIT

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

# HumuLIN 70/30

**Products Affected**

- HUMULIN 70/30

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Hyalgan

**Products Affected**

- HYALGAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Hycamtin

**Products Affected**

- HYCAMTIN ORAL

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

# Hydrocodone-Acetaminophen

**Products Affected**

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

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Hydrocodone-Acetaminophen

**Products Affected**

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

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Hydrocodone-Ibuprofen

**Products Affected**

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

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# HYDROmorphone HCl

**Products Affected**

- *hydromorphone hcl oral tablet*

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

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

# HYDROmorphone HCl ER

**Products Affected**

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

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# HYDROmorphone HCl ER

**Products Affected**

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

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Hymovis

**Products Affected**

- HYMOVIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Hyqvia

**Products Affected**

- HYQVIA

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

# Hysingla ER

**Products Affected**

- HYSINGLA ER

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ibrance

**Products Affected**

- IBRANCE

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

# Ibudone

**Products Affected**

- *ibudone oral tablet 5-200 mg*

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

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

# Iclusig

**Products Affected**

- ICLUSIG ORAL TABLET 15 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>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/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Idelvion

**Products Affected**

- IDELVION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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/Idhifa.html |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ilaris

**Products Affected**

- ILARIS

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

# Ilaris (150mg Delivered)

**Products Affected**

- ILARIS (150MG DELIVERED)

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

# Imatinib Mesylate

**Products Affected**

- *imatinib mesylate oral tablet 100 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Imatinib Mesylate

**Products Affected**

- *imatinib mesylate oral tablet 400 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Imbruvica

**Products Affected**

- IMBRUVICA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Impavido

**Products Affected**

- IMPAVIDO

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

# Increlex

**Products Affected**

- INCRELEX

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ingrezza

**Products Affected**

- INGREZZA ORAL CAPSULE 40 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Inlyta

**Products Affected**

- INLYTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Intelence

**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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Intelence

**Products Affected**

- INTELENCE ORAL TABLET 200 MG

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

# Intrarosa

**Products Affected**

- INTRAROSA

| | |
|---|---|
| **QL Criteria** | 1 insert Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Invokamet

**Products Affected**

- INVOKAMET

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

# Invokamet XR

**Products Affected**

- INVOKAMET XR

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

# Invokana

**Products Affected**

- INVOKANA

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

# Ipratropium Bromide

**Products Affected**

- *ipratropium bromide nasal*

| | |
|---|---|
| **QL Criteria** | 1 bottle Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Iprivask

**Products Affected**

- IPRIVASK

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

# Irbesartan

**Products Affected**

- *irbesartan*

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

# Irbesartan-Hydrochlorothiazide

**Products Affected**

- *irbesartan-hydrochlorothiazide*

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

# Isentress

**Products Affected**

- ISENTRESS ORAL TABLET

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

# Isentress

**Products Affected**

- ISENTRESS ORAL TABLET CHEWABLE

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

# Isentress HD

**Products Affected**

- ISENTRESS HD

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ixinity

**Products Affected**

- IXINITY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Jadenu

**Products Affected**

- JADENU

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Jakafi

**Products Affected**

- JAKAFI

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

# Janumet

**Products Affected**

- JANUMET

| | |
|---|---|
| **QL Criteria** | 999 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Janumet XR

**Products Affected**

- JANUMET XR

| | |
|---|---|
| **QL Criteria** | 999 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Januvia

**Products Affected**

- JANUVIA

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

# Jardiance

**Products Affected**

- JARDIANCE

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

# Jentadueto

**Products Affected**

- JENTADUETO

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | Annual Review: 05/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Jentadueto XR

**Products Affected**

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

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | Annual Review: 05/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Jentadueto XR

**Products Affected**

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

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

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

# Jevtana

**Products Affected**

- JEVTANA

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

# Jinteli

**Products Affected**

- *jinteli*

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

# Jublia

**Products Affected**

- JUBLIA

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

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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Juxtapid

**Products Affected**

- JUXTAPID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kadian

**Products Affected**

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

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kalbitor

**Products Affected**

- KALBITOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kalydeco

**Products Affected**

- KALYDECO

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

# Kalydeco

**Products Affected**

- KALYDECO

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

# Kanuma

**Products Affected**

- KANUMA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kepivance

**Products Affected**

- KEPIVANCE

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

# Kerydin

**Products Affected**

- KERYDIN

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

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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ketoconazole

**Products Affected**

- *ketoconazole oral*

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

# Ketorolac Tromethamine

**Products Affected**

- *ketorolac tromethamine ophthalmic*

| | |
|---|---|
| **QL Criteria** | 1 vial Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ketorolac Tromethamine

**Products Affected**

- *ketorolac tromethamine oral*

| | |
|---|---|
| **QL Criteria** | 20 tablets Per 28 dayss |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Keveyis

**Products Affected**

- KEVEYIS

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kineret

**Products Affected**

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Kineret.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Kineret.html |
| **QL Criteria** | 1 syringe Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kombiglyze XR

**Products Affected**

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

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kombiglyze XR

**Products Affected**

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

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentadueto; 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Korlym

**Products Affected**

- KORLYM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/antidiabetic agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Krystexxa

**Products Affected**

- KRYSTEXXA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Kuvan

**Products Affected**

- KUVAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# LamoTRIgine

**Products Affected**

- *lamotrigine oral tablet dispersible 50 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Epilepsy, Bipolar I Disorder (only for ODT formulation) |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of Epilepsy or Bipolar I disorder (Only ODT formulation will be reviewed for Bipolar I). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | Step Therapy |
| **ST Criteria** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lantus SoloStar

**Products Affected**

- LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# Latuda

**Products Affected**

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

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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 |

| 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 fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone) |
| **QL Criteria** | 15 bottles Per 1 fill |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: October 10, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lazanda

**Products Affected**

- LAZANDA NASAL SOLUTION 300 MCG/ACT

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

| 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 fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone) |
| **QL Criteria** | 4 bottles Per 30 days |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: October 10, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Leflunomide

**Products Affected**

- *leflunomide oral*

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

# Lemtrada

**Products Affected**

- LEMTRADA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 6 ML Per 365 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lenvima 10 MG Daily Dose

**Products Affected**

- LENVIMA 10 MG DAILY DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

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Next Update

# 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/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lenvima 18 MG Daily Dose

**Products Affected**

- LENVIMA 18 MG DAILY DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lenvima 20 MG Daily Dose

**Products Affected**

- LENVIMA 20 MG DAILY DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lenvima 24 MG Daily Dose

**Products Affected**

- LENVIMA 24 MG DAILY DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lenvima 8 MG Daily Dose

**Products Affected**

- LENVIMA 8 MG DAILY DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Letairis

**Products Affected**

- LETAIRIS

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

# Leukine

**Products Affected**

- LEUKINE INTRAVENOUS

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

# Leuprolide Acetate

**Products Affected**

- *leuprolide acetate injection*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Levorphanol Tartrate

**Products Affected**

- *levorphanol tartrate oral*

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

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

# Levulan Kerastick

**Products Affected**

- LEVULAN KERASTICK

| | |
|---|---|
| **QL Criteria** | 1 stick Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lidocaine

**Products Affected**

- *lidocaine external ointment*

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

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

# Lidocaine PAK

**Products Affected**

- *lidocaine pak*

| | |
|---|---|
| **QL Criteria** | 50 GM Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lidocaine-Prilocaine

**Products Affected**

- *lidocaine-prilocaine external cream*

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lidocaine-Tetracaine

**Products Affected**

- *lidocaine-tetracaine*

| | |
|---|---|
| **QL Criteria** | 30 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Linezolid

**Products Affected**

- *linezolid oral tablet*

| | |
|---|---|
| **QL Criteria** | 28 tablets Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Linzess

**Products Affected**

- LINZESS

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lonsurf

**Products Affected**

- LONSURF ORAL TABLET 15-6.14 MG

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

# Lorcet

**Products Affected**

- LORCET

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

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

# Lorcet HD

**Products Affected**

- LORCET HD

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lorcet Plus

**Products Affected**

- LORCET PLUS ORAL TABLET 7.5-325 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Losartan Potassium

**Products Affected**

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

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

# Lovastatin

**Products Affected**

- *lovastatin*

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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/ophthalmic_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lumigan

**Products Affected**

- LUMIGAN OPHTHALMIC SOLUTION
  0.01 %

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | open-angle glaucoma, ocular hypertension |
| **Exclusion Criteria** | |
| **Required Medical Information** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lumizyme

**Products Affected**

- LUMIZYME

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lupaneta Pack

**Products Affected**

- LUPANETA PACK

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

# Lupron Depot (1-Month)

**Products Affected**

- LUPRON DEPOT (1-MONTH)

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

# Lupron Depot (3-Month)

**Products Affected**

- LUPRON DEPOT (3-MONTH)

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

# Lupron Depot (4-Month)

**Products Affected**

- LUPRON DEPOT (4-MONTH)

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

# Lupron Depot (6-Month)

**Products Affected**

- LUPRON DEPOT (6-MONTH)

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

# Lupron Depot-Ped (1-Month)

**Products Affected**

- LUPRON DEPOT-PED (1-MONTH)

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

# Lupron Depot-Ped (3-Month)

**Products Affected**

- LUPRON DEPOT-PED (3-MONTH)

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lyza

**Products Affected**

- LYZA

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

# Macugen

**Products Affected**

- MACUGEN

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

# Makena

**Products Affected**

- MAKENA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Maprotiline HCl

**Products Affected**

- *maprotiline hcl*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Mekinist

**Products Affected**

- MEKINIST ORAL TABLET 0.5 MG

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

# Mekinist

**Products Affected**

- MEKINIST ORAL TABLET 2 MG

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Menopur

**Products Affected**

- MENOPUR

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

# Menostar

**Products Affected**

- MENOSTAR

| | |
|---|---|
| **QL Criteria** | 1 box (4 patches) Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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 |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Meperidine HCl

**Products Affected**

- *meperidine hcl oral tablet*

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

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

# Mephyton

**Products Affected**

- MEPHYTON

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

# Mesalamine

**Products Affected**

- *mesalamine oral tablet delayed release 1.2 gm*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methadone HCl

**Products Affected**

- *methadone hcl oral concentrate*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Required Medical Information** | (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). |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methadone HCl

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Required Medical Information** | (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). |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methadone HCl

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Required Medical Information** | (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). |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methadone HCl

**Products Affected**

- *methadone hcl oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. (4) FOR A DOCUMENTED DIAGNOSIS OF OPIOID ADDICTION (heroin or other morphine-like drugs): medication must be dispensed by a treatment program certified by SAMHSA (Substance Abuse and Mental Health Services Administration) and the patient will be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others. (Initiation/detoxification treatment = 1 month approval, continuation of therapy/maintenance treatment = 6 month approval). |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methadone HCl Intensol

**Products Affected**

- *methadone hcl intensol*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |

| PA Criteria | Criteria Details |
|---|---|
| **Required Medical Information** | (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). |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methamphetamine HCl

**Products Affected**

- *methamphetamine hcl*

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

# Methergine

**Products Affected**

- METHERGINE ORAL

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methylphenidate HCl ER

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Methylphenidate HCl ER

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Metoprolol Succinate ER

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Mimvey

**Products Affected**

- *mimvey*

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

# Mircera

**Products Affected**

- MIRCERA INJECTION SOLUTION PREFILLED SYRINGE

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

# Mirtazapine

**Products Affected**

- *mirtazapine oral*

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

# Mitigare

**Products Affected**

- MITIGARE

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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** | |

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: June 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Mometasone Furoate

**Products Affected**

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

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

# Monovisc

**Products Affected**

- MONOVISC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Montelukast Sodium

**Products Affected**

- *montelukast sodium oral*

| | |
|---|---|
| **QL Criteria** | 1 pack Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Montelukast Sodium

**Products Affected**

- *montelukast sodium oral*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Morphine Sulfate

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Morphine Sulfate

**Products Affected**

- *morphine sulfate oral tablet*

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

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

# Morphine Sulfate (Concentrate)

**Products Affected**

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

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

| PA Criteria | Criteria Details |
|---|---|
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Morphine Sulfate ER

**Products Affected**

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

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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** | (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** | |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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** | |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Morphine Sulfate ER Beads

**Products Affected**

- *morphine sulfate er beads*

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Mozobil

**Products Affected**

- MOZOBIL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Mozobil.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: October 27, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Multaq

**Products Affected**

- MULTAQ

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

# Mupirocin Calcium

**Products Affected**

- *mupirocin calcium*

| | |
|---|---|
| **QL Criteria** | 60 gram Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Myalept

**Products Affected**

- MYALEPT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Mytesi

**Products Affected**

- MYTESI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy |
| **Exclusion Criteria** | |
| **Required Medical Information** | Covered for adult members who have a documented diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month and who are currently stable on anti-retroviral therapy |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Myzilra

**Products Affected**

- *myzilra*

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

# Naglazyme

**Products Affected**

- NAGLAZYME

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Namenda XR

**Products Affected**

- NAMENDA XR

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

# Namzaric

**Products Affected**

- NAMZARIC

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

# Naratriptan HCl

**Products Affected**

- *naratriptan hcl*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Natpara

**Products Affected**

- NATPARA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 Jentadueto; 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Neulasta

**Products Affected**

- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

# Neupogen

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nevirapine ER

**Products Affected**

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

| | |
|---|---|
| **QL Criteria** | 3 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# NexAVAR

**Products Affected**

- NEXAVAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: October 06, 2017<br>Quantity Limits: August 25, 2015 |

# NexIUM 24HR

**Products Affected**

- NEXIUM 24HR

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nicoderm CQ

**Products Affected**

- NICODERM CQ

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

# Nicorelief

**Products Affected**

- *nicorelief mouth/throat gum*

| | |
|---|---|
| **QL Criteria** | 24 EA Per 1 DAYS |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nicotine

**Products Affected**

- *nicotine transdermal patch 24 hour*

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

# Nicotine Step 2

**Products Affected**

- *nicotine step 2*

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

# Nicotrol

**Products Affected**

- NICOTROL

| | |
|---|---|
| **QL Criteria** | 3 boxes-504 crtrg Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nicotrol NS

**Products Affected**

- NICOTROL NS

| | |
|---|---|
| **QL Criteria** | 4 bottles Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nifediac CC

**Products Affected**

- *nifediac cc oral tablet extended release 24 hour 30 mg*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# NIFEdipine ER Osmotic Release

**Products Affected**

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

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

# Nikki

**Products Affected**

- NIKKI

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

# Nitroglycerin

**Products Affected**

- *nitroglycerin translingual solution*

| | |
|---|---|
| **QL Criteria** | 12 grams Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nora-BE

**Products Affected**

- *nora-be*

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

# Norditropin FlexPro

**Products Affected**

- NORDITROPIN FLEXPRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Norlyroc

**Products Affected**

- NORLYROC

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Northera

**Products Affected**

- NORTHERA ORAL CAPSULE 300 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Novarel

**Products Affected**

- *novarel intramuscular solution reconstituted 10000 unit*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# NovoLOG FlexPen

**Products Affected**

- NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# NovoLOG Mix 70/30

**Products Affected**

- NOVOLOG MIX 70/30

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nucala

**Products Affected**

- NUCALA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nucynta

**Products Affected**

- NUCYNTA

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nucynta ER

**Products Affected**

- NUCYNTA ER

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nuedexta

**Products Affected**

- NUEDEXTA

| | |
|---|---|
| **QL Criteria** | 2 capsules Per 1 day |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nuplazid

**Products Affected**

- NUPLAZID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nutropin AQ NuSpin 10

**Products Affected**

- NUTROPIN AQ NUSPIN 10

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nutropin AQ NuSpin 20

**Products Affected**

- NUTROPIN AQ NUSPIN 20

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nutropin AQ NuSpin 5

**Products Affected**

- NUTROPIN AQ NUSPIN 5

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# NuvaRing

**Products Affected**

- NUVARING

| | |
|---|---|
| **QL Criteria** | 1 ring Per 28 dayss |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nuvigil

**Products Affected**

- NUVIGIL ORAL TABLET 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder |
| **Exclusion Criteria** | |
| **Required Medical Information** | FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ocaliva

**Products Affected**

- OCALIVA ORAL TABLET 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Primary_Biliary_Cholagitis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **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_Cholagitis.html |
| **QL Criteria** | 1 tablet Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Octagam

**Products Affected**

- OCTAGAM

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

# Octreotide Acetate

**Products Affected**

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

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

# Odefsey

**Products Affected**

- ODEFSEY

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

# Odomzo

**Products Affected**

- ODOMZO

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

# Ofev

**Products Affected**

- OFEV

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OLANZapine

**Products Affected**

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

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

# OLANZapine-FLUoxetine HCl

**Products Affected**

- *olanzapine-fluoxetine hcl*

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

# Olmesartan Medoxomil

**Products Affected**

- *olmesartan medoxomil oral*

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

# Olmesartan Medoxomil-HCTZ

**Products Affected**

- *olmesartan medoxomil-hctz*

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

# Olysio

**Products Affected**

- OLYSIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Omnitrope

**Products Affected**

- OMNITROPE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OneTouch Ultra 2

**Products Affected**

- ONETOUCH ULTRA 2

| | |
|---|---|
| **QL Criteria** | 1 KIT Per 365 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OneTouch Ultra Mini

**Products Affected**

- ONETOUCH ULTRA MINI

| | |
|---|---|
| **QL Criteria** | 1 KIT Per 365 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OneTouch Verio

**Products Affected**

- ONETOUCH VERIO IN VITRO STRIP

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OneTouch Verio IQ System

**Products Affected**

- ONETOUCH VERIO IQ SYSTEM

| | |
|---|---|
| **QL Criteria** | 1 KIT Per 365 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 Jentadueto; 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Opana ER

**Products Affected**

- OPANA ER ORAL TABLET ER 12 HOUR ABUSE-DETERRENT

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Opsumit

**Products Affected**

- OPSUMIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oravig

**Products Affected**

- ORAVIG

| | |
|---|---|
| **QL Criteria** | 14 tablets Per 1 fill |
| **Notes/ References** | Annual Review: 10/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Orencia

**Products Affected**

- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML

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

# Orfadin

**Products Affected**

- ORFADIN

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

# Orkambi

**Products Affected**

- ORKAMBI

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

# Orkambi

**Products Affected**

- ORKAMBI

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oseltamivir Phosphate

**Products Affected**

- *oseltamivir phosphate oral capsule*

| | |
|---|---|
| **QL Criteria** | 20 capsules Per 365 days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 Jentadueto; 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Osphena

**Products Affected**

- OSPHENA

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ovidrel

**Products Affected**

- OVIDREL

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

# Oxaydo

**Products Affected**

- OXAYDO

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

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

# Oxtellar XR

**Products Affected**

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

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of one month of oxcarbazepine |
| **QL Criteria** | 2 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxtellar XR

**Products Affected**

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 600 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of one month of oxcarbazepine |
| **QL Criteria** | 4 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyCODONE HCl

**Products Affected**

- *oxycodone hcl oral capsule*

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyCODONE HCl

**Products Affected**

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

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

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| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyCODONE HCl

**Products Affected**

- *oxycodone hcl oral tablet*

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

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

# 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** | |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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** | |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxycodone-Acetaminophen

**Products Affected**

- *oxycodone-acetaminophen 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 |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxycodone-Acetaminophen

**Products Affected**

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

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxycodone-Aspirin

**Products Affected**

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

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

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

# Oxycodone-Ibuprofen

**Products Affected**

- *oxycodone-ibuprofen*

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyCONTIN

**Products Affected**

- OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxymorphone HCl

**Products Affected**

- *oxymorphone hcl*

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

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyMORphone HCl ER

**Products Affected**

- *oxymorphone hcl er*

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

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

# Paliperidone ER

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Paxil

**Products Affected**

- PAXIL ORAL SUSPENSION

| | |
|---|---|
| **QL Criteria** | 30 ml Per 1 DAYS |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pegasys

**Products Affected**

- PEGASYS SUBCUTANEOUS SOLUTION

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

# Pegasys ProClick

**Products Affected**

- PEGASYS PROCLICK

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

# PegIntron

**Products Affected**

- PEGINTRON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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 |

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

# Perforomist

**Products Affected**

- PERFOROMIST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Chronic Obstructive Pulmonary Disorder (COPD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pioglitazone HCl

**Products Affected**

- *pioglitazone hcl*

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

# Pioglitazone HCl-Glimepiride

**Products Affected**

- *pioglitazone hcl-glimepiride*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Plegridy Starter Pack

**Products Affected**

- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 1 kit Per 365 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Plegridy Starter Pack

**Products Affected**

- PLEGRIDY STARTER PACK
  SUBCUTANEOUS SOLUTION
  PREFILLED SYRINGE

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

# Pomalyst

**Products Affected**

- POMALYST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 2 syringes Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pramipexole Dihydrochloride ER

**Products Affected**

- *pramipexole dihydrochloride er*

| | |
|---|---|
| **QL Criteria** | 1 TAB Per 1 DAILY |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prasugrel HCl

**Products Affected**

- *prasugrel hcl*

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

# Pravastatin Sodium

**Products Affected**

- *pravastatin sodium*

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

# Precision PCx

**Products Affected**

- PRECISION PCX

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision Point of Care Test

**Products Affected**

- PRECISION POINT OF CARE TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision Sof-Tact Test

**Products Affected**

- PRECISION SOF-TACT TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prefest

**Products Affected**

- PREFEST

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

# Pregnyl

**Products Affected**

- *pregnyl*

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

# Premarin

**Products Affected**

- PREMARIN ORAL

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

# Prempro

**Products Affected**

- PREMPRO

| | |
|---|---|
| **QL Criteria** | 1.5 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: October 06, 2017<br>Quantity Limits: August 25, 2015 |

# Prezista

**Products Affected**

- PREZISTA ORAL SUSPENSION

| | |
|---|---|
| **QL Criteria** | 2 bottles Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prezista

**Products Affected**

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

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

# PriLOSEC OTC

**Products Affected**

- PRILOSEC OTC

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Procrit

**Products Affected**

- PROCRIT

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

# Procysbi

**Products Affected**

- PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Procysbi

**Products Affected**

- PROCYSBI ORAL CAPSULE DELAYED RELEASE 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Progesterone Micronized

**Products Affected**

- *progesterone micronized oral*

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

# Prolastin-C

**Products Affected**

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

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

# Prolia

**Products Affected**

- PROLIA

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

# Promacta

**Products Affected**

- PROMACTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Promacta

**Products Affected**

- PROMACTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Propafenone HCl ER

**Products Affected**

- *propafenone hcl er*

| | |
|---|---|
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: October 06, 2017<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prudoxin

**Products Affected**

- PRUDOXIN

| | |
|---|---|
| **QL Criteria** | 45 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pulmozyme

**Products Affected**

- PULMOZYME

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

# Purixan

**Products Affected**

- PURIXAN

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

# Qbrelis

**Products Affected**

- QBRELIS

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

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# QuilliChew ER

**Products Affected**

- QUILLICHEW 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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

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Last Update 12/2017
Next Update

# 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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RA Nicotine

**Products Affected**

- *ra nicotine transdermal*

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

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Last Update 12/2017
Next Update

# Ranexa

**Products Affected**

- RANEXA

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

# 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** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otrexup_Rasuvo.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rayos

**Products Affected**

- RAYOS

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

# Rebetol

**Products Affected**

- REBETOL ORAL SOLUTION

| | |
|---|---|
| **QL Criteria** | 5 bottles Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebif Rebidose

**Products Affected**

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 12 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebif Rebidose Titration Pack

**Products Affected**

- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 12 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebif Titration Pack

**Products Affected**

- REBIF TITRATION PACK
  SUBCUTANEOUS SOLUTION
  PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 12 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rectiv

**Products Affected**

- RECTIV

| | |
|---|---|
| **QL Criteria** | 1 tube Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: November 06, 2017 |

# Relenza Diskhaler

**Products Affected**

- RELENZA DISKHALER

| | |
|---|---|
| **QL Criteria** | 40 disks Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Relistor

**Products Affected**

- RELISTOR ORAL

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

# Relistor

**Products Affected**

- RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML

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

# Relistor

**Products Affected**

- RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML

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

# 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 dayss |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Remicade

**Products Affected**

- REMICADE

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

# Remodulin

**Products Affected**

- REMODULIN

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

# Repaglinide-Metformin HCl

**Products Affected**

- *repaglinide-metformin hcl*

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

# Repatha

**Products Affected**

- REPATHA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 2 units Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Repatha Pushtronex System

**Products Affected**

- REPATHA PUSHTRONEX SYSTEM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 1 syringe Per 30 days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Repatha SureClick

**Products Affected**

- REPATHA SURECLICK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 2 units Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rescula

**Products Affected**

- RESCULA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | open-angle glaucoma, ocular hypertension |
| **Exclusion Criteria** | |
| **Required Medical Information** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Revatio

**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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Revlimid

**Products Affected**

- REVLIMID

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

# Rexulti

**Products Affected**

- REXULTI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Major depressive disorder, Schizophrenia |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of major depressive disorder or Schizophrenia |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | Step Therapy |
| **ST Criteria** | FOR MAJOR DEPRESSIVE DISORDER: 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<br>Step Therapy: October 27, 2017<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Reyataz

**Products Affected**

- REYATAZ ORAL CAPSULE 200 MG

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

# Riluzole

**Products Affected**

- *riluzole*

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

# Risedronate Sodium

**Products Affected**

- *risedronate sodium oral tablet 150 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of alendronate 70mg |
| **QL Criteria** | 1 tablet Per 1 month |
| **Notes/ References** | Annual Review: 06/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE M-TAB

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rituxan

**Products Affected**

- RITUXAN INTRAVENOUS SOLUTION

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

# Rivastigmine

**Products Affected**

- *rivastigmine*

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

# Rivastigmine Tartrate

**Products Affected**

- *rivastigmine tartrate*

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

# Rixubis

**Products Affected**

- RIXUBIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rizatriptan Benzoate

**Products Affected**

- *rizatriptan benzoate*

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

# ROPINIRole HCl ER

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ruconest

**Products Affected**

- RUCONEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sabril

**Products Affected**

- SABRIL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 6 packets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sabril

**Products Affected**

- SABRIL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 6 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Saizen

**Products Affected**

- SAIZEN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Samsca

**Products Affected**

- SAMSCA ORAL TABLET 15 MG

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

# Samsca

**Products Affected**

- SAMSCA ORAL TABLET 30 MG

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

# Sancuso

**Products Affected**

- SANCUSO

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

# Santyl

**Products Affected**

- SANTYL

| | |
|---|---|
| **QL Criteria** | 60 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Savella Titration Pack

**Products Affected**

- SAVELLA TITRATION PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Fibromyalgia |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of fibromyalgia |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Seebri Neohaler

**Products Affected**

- SEEBRI NEOHALER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Chronic Obstructive Pulmonary Disorder (COPD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Selzentry

**Products Affected**

- SELZENTRY ORAL SOLUTION

| | |
|---|---|
| **QL Criteria** | 8 bottles Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Selzentry

**Products Affected**

- SELZENTRY ORAL TABLET 25 MG

| | |
|---|---|
| **QL Criteria** | 8 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Serevent Diskus

**Products Affected**

- SEREVENT DISKUS

| | |
|---|---|
| **QL Criteria** | 2 blisters Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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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| | |
|---|---|
| **Revision Date** | Prior Authorization: December 20, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Signifor

**Products Affected**

- SIGNIFOR

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

# Sildenafil Citrate

**Products Affected**

- *sildenafil citrate oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 3 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Simponi

**Products Affected**

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi.html |
| **QL Criteria** | 1 syringe Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Simvastatin

**Products Affected**

- *simvastatin oral*

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

# Sirturo

**Products Affected**

- SIRTURO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antimycobacterial_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 188 EA Per 365 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sivextro

**Products Affected**

- SIVEXTRO ORAL

| | |
|---|---|
| **QL Criteria** | 6 tablets Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Skyla

**Products Affected**

- SKYLA

| | |
|---|---|
| **QL Criteria** | 1 IUD Per 365 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Solia

**Products Affected**

- *solia*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Somavert

**Products Affected**

- SOMAVERT

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sovaldi

**Products Affected**

- SOVALDI

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

# Spiriva HandiHaler

**Products Affected**

- SPIRIVA HANDIHALER

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

# Spiriva Respimat

**Products Affected**

- SPIRIVA RESPIMAT

| | |
|---|---|
| **QL Criteria** | 1 inhaler Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sprycel

**Products Affected**

- SPRYCEL ORAL TABLET 100 MG, 140 MG

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

# Sprycel

**Products Affected**

- SPRYCEL ORAL TABLET 20 MG, 50 MG, 70 MG, 80 MG

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

# Stelara

**Products Affected**

- STELARA INTRAVENOUS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Stiolto Respimat

**Products Affected**

- STIOLTO RESPIMAT

| | |
|---|---|
| **QL Criteria** | 1 inhaler Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>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, dexmethylphenidate/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Strensiq

**Products Affected**

- STRENSIQ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Stribild

**Products Affected**

- STRIBILD

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

# Striverdi Respimat

**Products Affected**

- STRIVERDI RESPIMAT

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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 |

| 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 fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone) |
| **QL Criteria** | 120 sprays Per 30 Days |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: October 10, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SulfaSALAzine

**Products Affected**

- *sulfasalazine oral*

| | |
|---|---|
| **QL Criteria** | 8 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sulfazine

**Products Affected**

- *sulfazine*

| | |
|---|---|
| **QL Criteria** | 8 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SUMAtriptan Succinate

**Products Affected**

- *sumatriptan succinate oral*

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

# SUMAtriptan Succinate

**Products Affected**

- *sumatriptan succinate subcutaneous solution 6 mg/0.5ml*

| | |
|---|---|
| **QL Criteria** | 8 vials Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Supprelin LA

**Products Affected**

- SUPPRELIN LA

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

# Sutent

**Products Affected**

- SUTENT ORAL CAPSULE 12.5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sutent

**Products Affected**

- SUTENT ORAL CAPSULE 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sutent

**Products Affected**

- SUTENT ORAL CAPSULE 37.5 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sylatron

**Products Affected**

- SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG

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

# Symbicort

**Products Affected**

- SYMBICORT

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

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Last Update 12/2017
Next Update

# 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<br>Step Therapy: November 06, 2017<br>Quantity Limits: August 25, 2015 |

# Synagis

**Products Affected**

- SYNAGIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 |

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

# Synarel

**Products Affected**

- SYNAREL

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

# Synera

**Products Affected**

- SYNERA

| | |
|---|---|
| **QL Criteria** | 10 patches Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synjardy

**Products Affected**

- SYNJARDY

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

# Synjardy XR

**Products Affected**

- SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synvisc One

**Products Affected**

- SYNVISC 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Syprine

**Products Affected**

- SYPRINE

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

# Taclonex

**Products Affected**

- TACLONEX EXTERNAL SUSPENSION

| | |
|---|---|
| **QL Criteria** | 60 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tacrolimus

**Products Affected**

- *tacrolimus external*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Atopic dermatitis, Vitiligo |
| **Exclusion Criteria** | |
| **Required Medical Information** | FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. FOR PROTOPIC 0.03%: A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required) or a documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or child 2 years of age or older and either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |

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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tafinlar

**Products Affected**

- TAFINLAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tagrisso

**Products Affected**

- TAGRISSO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tamiflu

**Products Affected**

- TAMIFLU ORAL CAPSULE

| | |
|---|---|
| **QL Criteria** | 20 capsules Per 365 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tarceva

**Products Affected**

- TARCEVA

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

# Targretin

**Products Affected**

- TARGRETIN EXTERNAL

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

# Tasigna

**Products Affected**

- TASIGNA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 4 capsules Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Taztia XT

**Products Affected**

- *taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg*

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

# Tecfidera

**Products Affected**

- TECFIDERA

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

# Tecfidera

**Products Affected**

- TECFIDERA

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

# Technivie

**Products Affected**

- TECHNIVIE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **QL Criteria** | 2 EA Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Telmisartan-Amlodipine

**Products Affected**

- *telmisartan-amlodipine*

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

# Telmisartan-HCTZ

**Products Affected**

- *telmisartan-hctz*

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Temozolomide

**Products Affected**

- *temozolomide*

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Testosterone

**Products Affected**

- *testosterone transdermal gel 12.5 mg/act (1%)*
- *testosterone transdermal gel 50 mg/5gm (1%)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, 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 |
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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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Testosterone

**Products Affected**

- *testosterone transdermal solution*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, patient will be using therapy for muscle building 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tetrabenazine

**Products Affected**

- *tetrabenazine oral tablet 12.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 8 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: May 31, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tetrabenazine

**Products Affected**

- *tetrabenazine oral tablet 25 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: May 31, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Thalomid

**Products Affected**

- THALOMID

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

# Thiola

**Products Affected**

- THIOLA

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TiaGABine HCl

**Products Affected**

- *tiagabine hcl oral tablet 4 mg*

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

# Tivicay

**Products Affected**

- TIVICAY

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

# Tivicay

**Products Affected**

- TIVICAY

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

# Tivorbex

**Products Affected**

- TIVORBEX

| | |
|---|---|
| **QL Criteria** | 3 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tobramycin

**Products Affected**

- *tobramycin inhalation*

| | |
|---|---|
| **QL Criteria** | 10 ml Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tracleer

**Products Affected**

- TRACLEER

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

# Tradjenta

**Products Affected**

- TRADJENTA

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

# TraMADol HCl

**Products Affected**

- *tramadol hcl oral*

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

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

# TraMADol HCl ER

**Products Affected**

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

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TraMADol HCl ER (Biphasic)

**Products Affected**

- *tramadol hcl er (biphasic)*

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 1 tablet Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tramadol-Acetaminophen

**Products Affected**

- *tramadol-acetaminophen*

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

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 8 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tranexamic Acid

**Products Affected**

- *tranexamic acid oral*

| | |
|---|---|
| **QL Criteria** | 30 tablets Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trelegy Ellipta

**Products Affected**

- TRELEGY ELLIPTA

| | |
|---|---|
| **QL Criteria** | 2 blisters Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trelstar Mixject

**Products Affected**

- TRELSTAR MIXJECT

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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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| | |
|---|---|
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tretinoin Microsphere

**Products Affected**

- *tretinoin microsphere*

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

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| | |
|---|---|
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tretinoin Microsphere Pump

**Products Affected**

- *tretinoin microsphere pump*

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

| | |
|---|---|
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tretin-X

**Products Affected**

- TRETIN-X EXTERNAL CREAM 0.075 %

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Triptodur

**Products Affected**

- TRIPTODUR

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

# Triumeq

**Products Affected**

- TRIUMEQ

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

# Trospium Chloride

**Products Affected**

- *trospium chloride*

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

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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 DAYSs |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 11, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trulicity

**Products Affected**

- TRULICITY

| | |
|---|---|
| **QL Criteria** | 4 injections Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Truvada

**Products Affected**

- TRUVADA

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

# Tudorza Pressair

**Products Affected**

- TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of one month each of Spiriva and Incruse Ellipta |
| **QL Criteria** | 1 inhaler Per 30 fills |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TussiCaps

**Products Affected**

- TUSSICAPS

| | |
|---|---|
| **QL Criteria** | 20 capsules Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tybost

**Products Affected**

- TYBOST

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

# Tykerb

**Products Affected**

- TYKERB

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

# Tymlos

**Products Affected**

- TYMLOS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tysabri

**Products Affected**

- TYSABRI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tyvaso

**Products Affected**

- TYVASO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tyvaso Refill

**Products Affected**

- TYVASO REFILL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tyvaso Starter

**Products Affected**

- TYVASO STARTER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ulesfia

**Products Affected**

- ULESFIA

| | |
|---|---|
| **QL Criteria** | 3 bottles Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ultravate

**Products Affected**

- ULTRAVATE EXTERNAL LOTION

| | |
|---|---|
| **QL Criteria** | 120 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Valchlor

**Products Affected**

- VALCHLOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Valcyte

**Products Affected**

- VALCYTE ORAL SOLUTION RECONSTITUTED

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

# ValGANciclovir HCl

**Products Affected**

- *valganciclovir hcl oral solution reconstituted*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopical.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1000 ML Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: November 13, 2017 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Valsartan

**Products Affected**

- *valsartan*

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

# Vantas

**Products Affected**

- VANTAS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Varubi

**Products Affected**

- VARUBI ORAL

| | |
|---|---|
| **QL Criteria** | 4 tablets Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vecamyl

**Products Affected**

- VECAMYL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Veletri

**Products Affected**

- VELETRI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Veltassa

**Products Affected**

- VELTASSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Veltin

**Products Affected**

- VELTIN

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venclexta

**Products Affected**

- VENCLEXTA ORAL TABLET 100 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venclexta

**Products Affected**

- VENCLEXTA ORAL TABLET 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venclexta Starting Pack

**Products Affected**

- VENCLEXTA STARTING PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venlafaxine HCl ER

**Products Affected**

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

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

# Ventavis

**Products Affected**

- VENTAVIS

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

# Verapamil HCl ER

**Products Affected**

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Verdrocet

**Products Affected**

- VERDROCET

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viberzi

**Products Affected**

- VIBERZI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Diarrhea-predominant irritable bowel syndrome (IBS) |
| **Exclusion Criteria** | No known or suspected history of any of the following: 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vicodin

**Products Affected**

- *vicodin oral tablet 5-300 mg*

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

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

# Vicodin ES

**Products Affected**

- *vicodin es oral tablet 7.5-300 mg*

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

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

# Vicodin HP

**Products Affected**

- *vicodin hp oral tablet 10-300 mg*

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

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viekira Pak

**Products Affected**

- VIEKIRA PAK

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

# Viekira XR

**Products Affected**

- VIEKIRA XR

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

# Vigabatrin

**Products Affected**

- *vigabatrin*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 6 packets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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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| | |
|---|---|
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vimizim

**Products Affected**

- VIMIZIM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vimpat

**Products Affected**

- VIMPAT ORAL SOLUTION

| | |
|---|---|
| **QL Criteria** | 40 ML Per 1 DAYS |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vimpat

**Products Affected**

- VIMPAT ORAL TABLET

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

# Viorele

**Products Affected**

- *viorele*

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

# Vistogard

**Products Affected**

- VISTOGARD

| | |
|---|---|
| **QL Criteria** | 20 packs Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Voltaren

**Products Affected**

- VOLTAREN TRANSDERMAL

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

# Vosevi

**Products Affected**

- VOSEVI

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

# Votrient

**Products Affected**

- VOTRIENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vpriv

**Products Affected**

- VPRIV

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vyvanse

**Products Affected**

- VYVANSE

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

# Vyvanse

**Products Affected**

- VYVANSE

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xalkori

**Products Affected**

- XALKORI

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

# Xatmep

**Products Affected**

- XATMEP

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Treatment of acute lymphoblastic leukemia (ALL) or polyarticular juvenile idiopathic arthritis (pJIA) in pediatric patients |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of Acute Lymphoblastic Leukemia (ALL) in a pediatric patient (18 years and younger) as part of a multi-phase, combination chemotherapy maintenance regimen or a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA) in pediatric patients (18 years and younger) who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs). Regardless of diagnosis, the patient must have a documented inability to swallow tablets/capsules. |
| **Age Restrictions** | Approved for those 18 years of age or younger |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: July 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xeljanz

**Products Affected**

- XELJANZ

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

# Xeljanz XR

**Products Affected**

- XELJANZ XR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html |
| **QL Criteria** | 1 tablet Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xeomin

**Products Affected**

- XEOMIN

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xgeva

**Products Affected**

- XGEVA

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xifaxan

**Products Affected**

- XIFAXAN ORAL TABLET 550 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea. |
| **Exclusion Criteria** | |
| **Required Medical Information** | FOR HEPATIC ENCHEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy. |
| **Age Restrictions** | 18 years or older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days. |
| **Other Criteria** | |
| **QL Criteria** | 3 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: November 29, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

2017 Aetna Pharmacy Drug Guide - Five Tier Open Value Small Group Formulary
Last Update 12/2017
Next Update

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xolair

**Products Affected**

- XOLAIR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xtampza ER

**Products Affected**

- XTAMPZA ER

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

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xtandi

**Products Affected**

- XTANDI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 4 capsules Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xulane

**Products Affected**

- XULANE

| | |
|---|---|
| **QL Criteria** | 1 box (3 patches) Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xylon

**Products Affected**

- XYLON

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Yervoy

**Products Affected**

- YERVOY

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

# Zafirlukast

**Products Affected**

- *zafirlukast*

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

# Zaleplon

**Products Affected**

- *zaleplon*

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

# Zarxio

**Products Affected**

- ZARXIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zavesca

**Products Affected**

- ZAVESCA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 3 capsules Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zegerid OTC

**Products Affected**

- ZEGERID OTC

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

# Zejula

**Products Affected**

- ZEJULA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zelboraf

**Products Affected**

- ZELBORAF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zemaira

**Products Affected**

- ZEMAIRA

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

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zenatane

**Products Affected**

- ZENATANE ORAL CAPSULE 30 MG

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

# Zenzedi

**Products Affected**

- ZENZEDI ORAL TABLET 10 MG, 5 MG

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

# Zepatier

**Products Affected**

- ZEPATIER

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

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zileuton ER

**Products Affected**

- *zileuton er*

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

# Zioptan

**Products Affected**

- ZIOPTAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | open-angle glaucoma, ocular hypertension |
| **Exclusion Criteria** | |
| **Required Medical Information** | 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ziprasidone HCl

**Products Affected**

- *ziprasidone hcl*

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

# 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** | (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** | |

| 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zoladex

**Products Affected**

- ZOLADEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zolinza

**Products Affected**

- ZOLINZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ZOLMitriptan

**Products Affected**

- *zolmitriptan oral tablet 5 mg*

| | |
|---|---|
| **QL Criteria** | 3 tablets Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zonalon

**Products Affected**

- ZONALON

| | |
|---|---|
| **QL Criteria** | 45 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zorbtive

**Products Affected**

- ZORBTIVE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# 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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zurampic

**Products Affected**

- ZURAMPIC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Treatment of hyperuricemia associated with gout |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of gout, and will be used in combination with a xanthine oxidase inhibitor (allopurinol OR febuxostat) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented 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<br>Step Therapy: October 04, 2017<br>Quantity Limits: August 25, 2015 |

# Zyban

**Products Affected**

- ZYBAN

| | |
|---|---|
| **QL Criteria** | 2 tablet Per 1 DAYS |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zydelig

**Products Affected**

- ZYDELIG

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

# Zyflo

**Products Affected**

- ZYFLO

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

# Zyflo CR

**Products Affected**

- ZYFLO CR

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

# Zykadia

**Products Affected**

- ZYKADIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 5 CAP Per 1 DAYS |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zytiga

**Products Affected**

- ZYTIGA ORAL TABLET 250 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zytiga

**Products Affected**

- ZYTIGA ORAL TABLET 500 MG

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

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