

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Abilify

Products Affected

- ABILIFY ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, Tourette's Disorder
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of Schizophrenia, Bipolar Disorder, Major Depressive Disorder (MDD), Autistic Disorder, or Tourette's Disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR A DIAGNOSIS OF BIPOLAR DISORDER OR SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) and Latuda. FOR ALL OTHER DIAGNOSIS: A documented contraindication, intolerance, allergy, or failure of one month of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone).
QL Criteria	1 tablet Per 1 day
Notes/References	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Acamprosate Calcium

Products Affected

- *acamprosate calcium*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Accolate

Products Affected

- ACCOLATE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Accu-Chek Compact Plus Care

Products Affected

- ACCU-CHEK COMPACT PLUS CARE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Accu-Chek Multiclix Lancet Dev

Products Affected

- ACCU-CHEK MULTICLIX LANCET DEV

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Acetaminophen-Codeine

Products Affected

- *acetaminophen-codeine oral solution*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Acetaminophen-Codeine #3

Products Affected

- *acetaminophen-codeine #3*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Aciphex

Products Affected

- ACIPHEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 generic RX or OTC proton pump inhibitors (i.e. esomeprazole mag, lansoprazole, omeprazole, pantoprazole, rabeprazole)
QL Criteria	1 capsule Per 1 DAY
Notes/References	Annual Review: 02/2017

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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)
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 02/2017

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Acitretin

Products Affected

- *acitretin*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Actemra

Products Affected

- ACTEMRA INTRAVENOUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Actemra

Products Affected

- ACTEMRA SUBCUTANEOUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Actimmune

Products Affected

- ACTIMMUNE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Actiq

Products Affected

- ACTIQ

PA Criteria	Criteria Details
Covered Uses	For pain due to malignant diagnosis only
Exclusion Criteria	Use in non-malignant pain
Required Medical Information	A 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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Activella

Products Affected

- ACTIVELLA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Actonel

Products Affected

- ACTONEL ORAL TABLET 150 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	0.04 tabs Per 1 DAYS
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Actonel

Products Affected

- ACTONEL ORAL TABLET 30 MG
- ACTONEL ORAL TABLET 5 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Actonel

Products Affected

- ACTONEL ORAL TABLET 35 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Actoplus Met

Products Affected

- ACTOPLUS MET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Actoplus met XR

Products Affected

- ACTOPLUS MET XR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Actos

Products Affected

- ACTOS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Aczone

Products Affected

- ACZONE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Adagen

Products Affected

- ADAGEN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Adalat CC

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Adalat CC

Products Affected

- ADALAT CC ORAL TABLET
EXTENDED RELEASE 24 HOUR 60 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Adcirca

Products Affected

- ADCIRCA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Adderall

Products Affected

- ADDERALL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Adderall XR

Products Affected

- ADDERALL XR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Adefovir Dipivoxil

Products Affected

- *adefovir dipivoxil*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Adempas

Products Affected

- ADEMPAS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Advair Diskus

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Advair Diskus

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Advair HFA

Products Affected

- ADVAIR HFA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Advate

Products Affected

- ADVATE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Advocate Duo

Products Affected

- ADVOCATE DUO DEVICE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Adynovate

Products Affected

- *adynovate*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Adyphren

Products Affected

- ADYPHREN

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Adyphren Amp II

Products Affected

- ADYPHREN AMP II

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Adyphren II

Products Affected

- ADYPHREN II

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Adzenys XR-ODT

Products Affected

- ADZENYS XR-ODT

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Aerospan

Products Affected

- AEROSPAN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Afeditab CR

Products Affected

- *afeditab cr oral tablet extended release 24 hour 30 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Afeditab CR

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Afinitor Disperz

Products Affected

- AFINITOR DISPERZ

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Afrezza

Products Affected

- AFREZZA INHALATION POWDER 12 UNIT, 8 UNIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Afrezza

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Afrezza

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Afstyla

Products Affected

- AFSTYLA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

AgaMatrix Presto

Products Affected

- AGAMATRIX PRESTO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

AirDuo RespiClick 113/14

Products Affected

- AIRDUO RESPICLICK 113/14

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

AirDuo RespiClick 232/14

Products Affected

- AIRDUO RESPICLICK 232/14

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

AirDuo RespiClick 55/14

Products Affected

- AIRDUO RESPICLICK 55/14

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Akynzeo

Products Affected

- AKYNZEO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Albenza

Products Affected

- ALBENZA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Aldara

Products Affected

- ALDARA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Aldurazyme

Products Affected

- ALDURAZYME

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Alecensa

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Alendronate Sodium

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Alendronate Sodium

Products Affected

- *alendronate sodium oral tablet 35 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Alfuzosin HCl ER

Products Affected

- *alfuzosin hcl er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Alinia

Products Affected

- ALINIA ORAL SUSPENSION
RECONSTITUTED

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Alinia

Products Affected

- ALINIA ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Almotriptan Malate

Products Affected

- *almotriptan malate*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Alogliptin Benzoate

Products Affected

- *alogliptin benzoate*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Alogliptin-Metformin HCl

Products Affected

- *alogliptin-metformin hcl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Alogliptin-Pioglitazone

Products Affected

- *alogliptin-pioglitazone*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Alosetron HCl

Products Affected

- *alose tron hcl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Alphanate/VWF Complex/Human

Products Affected

- ALPHANATE/VWF COMPLEX/HUMAN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

AlphaNine SD

Products Affected

- ALPHANINE SD

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Alprolix

Products Affected

- ALPROLIX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Altoprev

Products Affected

- ALTOPREV

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Alunbrig

Products Affected

- ALUNBRIG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Alvesco

Products Affected

- ALVESCO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ambien

Products Affected

- AMBIEN ORAL TABLET 10 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Ambien

Products Affected

- AMBIEN ORAL TABLET 5 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Ambien CR

Products Affected

- AMBIEN CR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Amerge

Products Affected

- AMERGE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Amitiza

Products Affected

- AMITIZA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Amlodipine Besylate-Valsartan

Products Affected

- *amlodipine besylate-valsartan*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Amlodipine-Olmesartan

Products Affected

- *amlodipine-olmesartan*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Amlodipine-Valsartan-HCTZ

Products Affected

- *amlodipine-valsartan-hctz*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Amnesteem

Products Affected

- *amnesteem*

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ampyra

Products Affected

- AMPYRA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	
QL Criteria	1 1.25 gm packet Per 1 day

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%
QL Criteria	2.5 grams Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
 Formulary
 Last Update 12/2017
 Next Update

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	
QL Criteria	5 grams-2 packets Per 1 day

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%
QL Criteria	10 grams Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	
QL Criteria	4 pumps Per 1 day

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Anoro Ellipta

Products Affected

- ANORO ELLIPTA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Antara

Products Affected

- ANTARA ORAL CAPSULE 30 MG, 90 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Anzemet

Products Affected

- ANZEMET ORAL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

APAP-Caff-Dihydrocodeine

Products Affected

- *apap-caff-dihydrocodeine oral capsule*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Apidra

Products Affected

- APIDRA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Apidra SoloStar

Products Affected

- APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Aprepitant

Products Affected

- *aprepitant oral capsule 125 mg, 40 mg, 80 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Aprepitant

Products Affected

- *aprepitant oral capsule 80 & 125 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Apriso

Products Affected

- APRISO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Aptensio XR

Products Affected

- APTENSIO XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 capsule Per 1 Day
Notes/References	Annual Review: 05/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Aptiom

Products Affected

- APTIOM ORAL TABLET 200 MG, 600 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Aptiom

Products Affected

- APTIOM ORAL TABLET 400 MG, 800 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Aralast NP

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Aranesp (Albumin Free)

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Arava

Products Affected

- ARAVA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Arcalyst

Products Affected

- ARCALYST

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Arcapta Neohaler

Products Affected

- ARCAPTA NEOHALER

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Aricept

Products Affected

- ARICEPT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ARIPiprazole

Products Affected

- *aripiprazole oral solution*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

ARIPiprazole

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Arixtra

Products Affected

- ARIXTRA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

ArmonAir RespiClick 113

Products Affected

- ARMONAIR RESPICLICK 113

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

ArmonAir RespiClick 232

Products Affected

- ARMONAIR RESPICLICK 232

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

ArmonAir RespiClick 55

Products Affected

- ARMONAIR RESPICLICK 55

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Arnuity Ellipta

Products Affected

- ARNUITY ELLIPTA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	120 tablets Per 3 Days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Asacol HD

Products Affected

- ASACOL HD

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Delzicol, Lialda, or Pentasa
QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ascomp-Codeine

Products Affected

- *ascomp-codeine*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 0.5 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Astagraf XL

Products Affected

- ASTAGRAF XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 1 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Atacand

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Atacand

Products Affected

- ATACAND ORAL TABLET 32 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Atacand HCT

Products Affected

- ATACAND HCT ORAL TABLET 16-12.5
MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Atacand HCT

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Atelvia

Products Affected

- ATELVIA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Atomoxetine HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Atomoxetine HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Atripla

Products Affected

- ATRIPLA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Atrovent HFA

Products Affected

- ATROVENT HFA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Aubagio

Products Affected

- AUBAGIO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Austedo

Products Affected

- AUSTEDO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Avalide

Products Affected

- AVALIDE ORAL TABLET 150-12.5 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Avalide

Products Affected

- AVALIDE ORAL TABLET 300-12.5 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Avandia

Products Affected

- AVANDIA ORAL TABLET 2 MG, 4 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Avapro

Products Affected

- AVAPRO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	
Notes/References	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Avodart

Products Affected

- AVODART

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Avonex

Products Affected

- AVONEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Avonex Pen

Products Affected

- AVONEX PEN INTRAMUSCULAR
AUTO-INJECTOR KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Avonex Prefilled

Products Affected

- AVONEX PREFILLED
INTRAMUSCULAR PREFILLED
SYRINGE KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Axert

Products Affected

- AXERT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Azilect

Products Affected

- AZILECT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Azor

Products Affected

- AZOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Azulfidine

Products Affected

- AZULFIDINE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Azulfidine EN-tabs

Products Affected

- AZULFIDINE EN-TABS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Bactroban

Products Affected

- BACTROBAN EXTERNAL CREAM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Balsalazide Disodium

Products Affected

- *balsalazide disodium*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Banzel

Products Affected

- BANZEL ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Baraclude

Products Affected

- BARACLUDGE ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Basaglar KwikPen

Products Affected

- BASAGLAR KWIKPEN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Revision Date	Prior Authorization: November 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Bayer Contour Link Monitor

Products Affected

- BAYER CONTOUR LINK MONITOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Bayer Contour Monitor

Products Affected

- BAYER CONTOUR MONITOR KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bayer Contour Next EZ

Products Affected

- BAYER CONTOUR NEXT EZ

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Bayer Contour next Link

Products Affected

- BAYER CONTOUR NEXT LINK

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bayer Contour Next Monitor

Products Affected

- BAYER CONTOUR NEXT MONITOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Bebulin

Products Affected

- BEBULIN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Beconase AQ

Products Affected

- BECONASE AQ

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 films Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Belsomra

Products Affected

- BELSOMRA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Benicar

Products Affected

- BENICAR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Benlysta

Products Affected

- BENLYSTA INTRAVENOUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Berinert

Products Affected

- BERINERT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Betamethasone Dipropionate Aug

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Betamethasone Dipropionate Aug

Products Affected

- *betamethasone dipropionate aug external lotion*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Betaseron

Products Affected

- BETASERON SUBCUTANEOUS KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bethkis

Products Affected

- BETHKIS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Bevespi Aerosphere

Products Affected

- BEVESPI AEROSPHERE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bevyxxa

Products Affected

- BEVYXXA

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE.
Exclusion Criteria	Active pathological bleeding, severe hypersensitivity reaction to Bevyxxa, or for anyone with prosthetic heart valves.
Required Medical Information	Member is requesting product for use of prophylaxis of VTE and is currently taking Bevyxxa during hospitalization and will be continuing therapy following discharge from the hospital.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of enoxaparin or dalteparin, or heparin
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: October 04, 2017 Step Therapy: October 05, 2017 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bexarotene

Products Affected

- *bexarotene*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bicalutamide

Products Affected

- *bicalutamide*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bimatoprost

Products Affected

- *bimatoprost ophthalmic*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bivigam

Products Affected

- BIVIGAM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Boniva

Products Affected

- BONIVA ORAL TABLET 150 MG

QL Criteria	0.04 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Bosulif

Products Affected

- BOSULIF

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Botox

Products Affected

- BOTOX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Botox Cosmetic

Products Affected

- BOTOX COSMETIC INTRAMUSCULAR SOLUTION RECONSTITUTED 50 UNIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Breo Ellipta

Products Affected

- BREO ELLIPTA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Breo Ellipta

Products Affected

- BREO ELLIPTA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Brilinta

Products Affected

- BRILINTA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Brisdelle

Products Affected

- BRISDELLE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Briviact

Products Affected

- BRIVIACT ORAL SOLUTION

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Briviact

Products Affected

- BRIVIACT ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Brovana

Products Affected

- BROVANA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Budesonide

Products Affected

- *budesonide inhalation*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bunavail

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Buphenyl

Products Affected

- BUPHENYL ORAL POWDER 3 GM/TSP

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	4 patches Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

BuPROPion HCl ER (XL)

Products Affected

- *bupropion hcl er (xl)*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Butorphanol Tartrate

Products Affected

- *butorphanol tartrate nasal*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 bottles Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	4 patches Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Bydureon

Products Affected

- BYDUREON SUBCUTANEOUS PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Byetta 10 MCG Pen

Products Affected

- BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
QL Criteria	1 pen Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Byetta 5 MCG Pen

Products Affected

- BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
QL Criteria	1 pen Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bystolic

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Bystolic

Products Affected

- BYSTOLIC ORAL TABLET 20 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Byvalson

Products Affected

- BYVALSON

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Calcipotriene

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Calcitrene

Products Affected

- *calcitrene*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Canasa

Products Affected

- CANASA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Candesartan Cilexetil

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Capecitabine

Products Affected

- *capecitabine*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 300 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Carbaglu

Products Affected

- CARBAGLU

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cardizem LA

Products Affected

- CARDIZEM LA ORAL TABLET
EXTENDED RELEASE 24 HOUR 120 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cardizem LA

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cardizem LA

Products Affected

- CARDIZEM LA ORAL TABLET
EXTENDED RELEASE 24 HOUR 240 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cardizem LA

Products Affected

- CARDIZEM LA ORAL TABLET
EXTENDED RELEASE 24 HOUR 360 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cardura XL

Products Affected

- CARDURA XL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Carimune NF

Products Affected

- CARIMUNE NF INTRAVENOUS SOLUTION RECONSTITUTED 12 GM, 6 GM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cartia XT

Products Affected

- *cartia xt oral capsule extended release 24 hour 120 mg, 300 mg*
- *cartia xt oral capsule extended release 24 hour 180 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cartia XT

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Casodex

Products Affected

- CASODEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Cayston

Products Affected

- CAYSTON

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Cefixime

Products Affected

- *cefixime*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

CeleBREX

Products Affected

- CELEBREX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Celecoxib

Products Affected

- *celecoxib oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

CeleXA

Products Affected

- CELEXA ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Centany

Products Affected

- CENTANY

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Cerdelga

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cerezyme

Products Affected

- CEREZYME INTRAVENOUS SOLUTION
RECONSTITUTED 400 UNIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cesamet

Products Affected

- CESAMET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Cevimeline HCl

Products Affected

- *cevimeline hcl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Chantix

Products Affected

- CHANTIX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Chantix Continuing Month Pak

Products Affected

- CHANTIX CONTINUING MONTH PAK

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Chantix Starting Month Pak

Products Affected

- CHANTIX STARTING MONTH PAK

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Chorionic Gonadotropin

Products Affected

- *chorionic gonadotropin intramuscular*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cialis

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Ciclodan

Products Affected

- CICLODAN EXTERNAL SOLUTION

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Ciclopirox

Products Affected

- *ciclopirox external solution*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cimzia

Products Affected

- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cimzia Prefilled

Products Affected

- CIMZIA PREFILLED

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cimzia Starter Kit

Products Affected

- CIMZIA STARTER KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cinryze

Products Affected

- CINRYZE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 10 mg, 20 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 40 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Claravis

Products Affected

- *claravis*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Clarinet

Products Affected

- CLARINEX ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Clarinet-D 12 Hour

Products Affected

- CLARINEX-D 12 HOUR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Clever Chek Auto-Code

Products Affected

- CLEVER CHEK AUTO-CODE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Clever Choice Micro System

Products Affected

- CLEVER CHOICE MICRO SYSTEM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Climara

Products Affected

- CLIMARA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Climara Pro

Products Affected

- CLIMARA PRO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Clobetasol Propionate

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Clobetasol Propionate

Products Affected

- *clobetasol propionate external foam*
- *clobetasol propionate external solution*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Clobetasol Propionate

Products Affected

- *clobetasol propionate external liquid*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Clobetasol Propionate

Products Affected

- *clobetasol propionate external lotion*
- *clobetasol propionate external shampoo*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Clobetasol Propionate E

Products Affected

- *clobetasol propionate e*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Clobetasol Propionate Emulsion

Products Affected

- *clobetasol propionate emulsion*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Clodan

Products Affected

- *clodan external shampoo*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

CloNIDine HCl ER

Products Affected

- *clonidine hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

CloZAPine

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

CloZAPine

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 200 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Clozaril

Products Affected

- CLOZARIL ORAL TABLET 100 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Clozaril

Products Affected

- CLOZARIL ORAL TABLET 25 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Coagadex

Products Affected

- COAGADEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Codeine Sulfate

Products Affected

- *codeine sulfate oral tablet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Colazal

Products Affected

- COLAZAL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Colchicine

Products Affected

- *colchicine oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

CombiPatch

Products Affected

- COMBIPATCH

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Combivent Respimat

Products Affected

- COMBIVENT RESPIMAT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cometriq (100 mg Daily Dose)

Products Affected

- COMETRIQ (100 MG DAILY DOSE)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cometriq (60 mg Daily Dose)

Products Affected

- COMETRIQ (60 MG DAILY DOSE)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Complera

Products Affected

- COMPLERA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Concerta

Products Affected

- CONCERTA ORAL TABLET EXTENDED
RELEASE 18 MG, 27 MG, 54 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Concerta

Products Affected

- CONCERTA ORAL TABLET EXTENDED
RELEASE 36 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Copaxone

Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cordran

Products Affected

- CORDRAN EXTERNAL TAPE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Coreg CR

Products Affected

- COREG CR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Corifact

Products Affected

- CORIFACT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Corlanor

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	FDA labeled use for heart failure
Exclusion Criteria	
Required Medical Information	Documentation of stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, and who are on maximally tolerated doses of beta-blockers (bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate/metoprolol succinate-HCTZ, nebulolol) or have a documented contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one of the following: ACE Inhibitor or ACE Inhibitor/HCTZ combination or Angiotensin-Receptor Blocker or Angiotensin-Receptor Blocker/HCTZ combination
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: July 25, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cormax Scalp Application

Products Affected

- CORMAX SCALP APPLICATION

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cosentyx

Products Affected

- COSENTYX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Cosentyx Sensoready Pen

Products Affected

- COSENTYX SENSOREADY PEN
SUBCUTANEOUS SOLUTION AUTO-
INJECTOR 150 MG/ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cotellic

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	63 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Cotempla XR-ODT

Products Affected

- COTEMPLA XR-ODT

PA Criteria	Criteria Details
Covered Uses	Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in pediatric patients 6 to 17 years of age.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
Age Restrictions	Approved for patients 6 to 17 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cozaar

Products Affected

- COZAAR ORAL TABLET 25 MG
- COZAAR ORAL TABLET 50 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Crestor

Products Affected

- CRESTOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cuprimine

Products Affected

- CUPRIMINE ORAL CAPSULE 250 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Cuvitru

Products Affected

- CUVITRU

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

CVS Nicotine

Products Affected

- *cvs nicotine transdermal patch 24 hour*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

CVS Nicotine Polacrilex

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

CVS NTS Step 1

Products Affected

- *cvs nts step 1*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Cycloset

Products Affected

- CYCLOSET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED
RELEASE PARTICLES 20 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED
RELEASE PARTICLES 30 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED
RELEASE PARTICLES 60 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Cystadane

Products Affected

- CYSTADANE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cystagon

Products Affected

- CYSTAGON

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Cystaran

Products Affected

- CYSTARAN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Daklinza

Products Affected

- DAKLINZA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Daklinza

Products Affected

- DAKLINZA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Daliresp

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	A Documented diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of two of the following: Breo, Symbicort, Anoro, Stiolto, Incruse, or Spiriva
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: July 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Dapsone

Products Affected

- *dapsone external*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Darifenacin Hydrobromide ER

Products Affected

- *darifenacin hydrobromide er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Daytrana

Products Affected

- DAYTRANA

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 patch Per 1 day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Delzicol

Products Affected

- DELZICOL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Demerol

Products Affected

- DEMEROL 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Depen Titratabs

Products Affected

- DEPEN TITRATABS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Descovy

Products Affected

- DESCOVY

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Desloratadine

Products Affected

- *desloratadine*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Desoxyn

Products Affected

- DESOXYN

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tablets Per 1 DAYS
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Desvenlafaxine ER

Products Affected

- *desvenlafaxine er*

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Detrol

Products Affected

- DETROL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Detrol LA

Products Affected

- DETROL LA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dexedrine

Products Affected

- DEXEDRINE ORAL CAPSULE
EXTENDED RELEASE 24 HOUR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	3 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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)
QL Criteria	1 capsule Per 1 day
Notes/References	Annual Review: 02/2017

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

QL Criteria	40 milliliters Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

DiazePAM

Products Affected

- *diazepam rectal*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Diclegis

Products Affected

- DICLEGIS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 1 %*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Differin

Products Affected

- DIFFERIN EXTERNAL GEL 0.1 %
- DIFFERIN EXTERNAL LOTION
- DIFFERIN EXTERNAL GEL 0.3 %

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dificid

Products Affected

- DIFICID

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Dihydroergotamine Mesylate

Products Affected

- *dihydroergotamine mesylate nasal*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dilaudid

Products Affected

- DILAUDID ORAL LIQUID

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Dilaudid

Products Affected

- DILAUDID 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Diltiazem CD

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Diltiazem CD

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

DiltiaZEM CD

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Diltiazem HCl ER

Products Affected

- *diltiazem hcl er oral capsule extended release 12 hour 120 mg*
- *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Diltiazem HCl ER

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Diltiazem HCl ER Beads

Products Affected

- *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg*
- *diltiazem hcl er beads oral capsule extended release 24 hour 420 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Diltiazem HCl ER Beads

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Diltiazem HCl ER Coated Beads

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

DiTIAZem HCl ER Coated Beads

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

DiTIAZem HCl ER Coated Beads

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Dilt-XR

Products Affected

- *dilt-xr oral capsule extended release 24 hour*
120 mg, 180 mg

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Dilt-XR

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Diovan

Products Affected

- DIOVAN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Diovan HCT

Products Affected

- DIOVAN HCT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Dipentum

Products Affected

- DIPENTUM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ditropan XL

Products Affected

- DITROPAN XL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Dolophine

Products Affected

- DOLOPHINE

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	6 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Donepezil HCl

Products Affected

- *donepezil hcl oral tablet 10 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Donepezil HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dovonex

Products Affected

- DOVONEX EXTERNAL CREAM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Doxepin HCl

Products Affected

- *doxepin hcl external*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Doxercalciferol

Products Affected

- *doxercalciferol oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dronabinol

Products Affected

- *dronabinol*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Duavee

Products Affected

- DUAVEE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Duetact

Products Affected

- DUETACT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Dulera

Products Affected

- DULERA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 20 mg, 60 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

DULoxetine HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dupixent

Products Affected

- DUPIXENT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Duragesic-100

Products Affected

- DURAGESIC-100

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Duragesic-12

Products Affected

- DURAGESIC-12

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Duragesic-25

Products Affected

- DURAGESIC-25

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Duragesic-50

Products Affected

- DURAGESIC-50

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Duragesic-75

Products Affected

- DURAGESIC-75

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Durolane

Products Affected

- DUROLANE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dutasteride

Products Affected

- *dutasteride*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Duzallo

Products Affected

- DUZALLO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Dyanavel XR

Products Affected

- DYANAVEL XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	240 ML Per 30 days
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Dysport

Products Affected

- DYSPOORT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Econazole Nitrate

Products Affected

- *econazole nitrate external*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Edarbi

Products Affected

- EDARBI

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Edurant

Products Affected

- EDURANT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Effexor XR

Products Affected

- EFFEXOR XR ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 150 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Effexor XR

Products Affected

- EFFEXOR XR ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 37.5 MG
- EFFEXOR XR ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 75 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Effient

Products Affected

- EFFIENT

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS) managed with percutaneous coronary intervention which includes unstable angina or non-ST elevation myocardial infarction or ST elevation myocardial infarction (MI)
Exclusion Criteria	History of Stroke or transient ischemic attack (TIA)
Required Medical Information	Member has a documented diagnosis of acute coronary syndrome (ACS) and is managed by percutaneous coronary intervention (PCI), which includes unstable angina, non-ST-elevation myocardial infarction (NSTEMI), or ST -elevation myocardial infarction (STEMI) managed with primary or delayed PCI and member has no prior history of stroke or transient ischemic attack (TIA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: May 22, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Elaprase

Products Affected

- ELAPRASE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Elelyso

Products Affected

- ELELYSO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Elestrin

Products Affected

- ELESTRIN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Eletriptan Hydrobromide

Products Affected

- *eletriptan hydrobromide*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Elidel

Products Affected

- ELIDEL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Eligard

Products Affected

- ELIGARD

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Elmiron

Products Affected

- ELMIRON

QL Criteria	90 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Eloctate

Products Affected

- ELOCTATE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Embeda

Products Affected

- EMBEDA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Emend

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Emsam

Products Affected

- EMSAM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Emtriva

Products Affected

- EMTRIVA ORAL CAPSULE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Emverm

Products Affected

- EMVERM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Enablex

Products Affected

- ENABLEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Enablex

Products Affected

- ENABLEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 25 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Enbrel.html
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 50 MG/ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Enbrel Mini

Products Affected

- ENBREL MINI

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Enbrel SureClick

Products Affected

- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Enstilar

Products Affected

- ENSTILAR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Entecavir

Products Affected

- *entecavir*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Entecavir

Products Affected

- *entecavir*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Entresto

Products Affected

- ENTRESTO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Entyvio

Products Affected

- ENTYVIO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Epaned

Products Affected

- EPANED ORAL SOLUTION

QL Criteria	1 bottle Per 30 Days
Notes/ References	Annual Review: 08/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Epclusa

Products Affected

- EPCLUSA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

EPINEPHrine

Products Affected

- *epinephrine injection solution auto-injector*

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

EpiPen 2-Pak

Products Affected

- EPIPEN 2-PAK INJECTION SOLUTION
AUTO-INJECTOR

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

EpiPen Jr 2-Pak

Products Affected

- EPIPEN JR 2-PAK INJECTION
SOLUTION AUTO-INJECTOR

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

EPIsnap

Products Affected

- EPISNAP

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Epogen

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Epoprostenol Sodium

Products Affected

- *epoprostenol sodium*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

EQ Nicotine

Products Affected

- *eq nicotine transdermal*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Erivedge

Products Affected

- ERIVEDGE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Esbriet

Products Affected

- ESBRIET ORAL TABLET 267 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Esbriet

Products Affected

- ESBRIET ORAL TABLET 801 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral solution*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Escitalopram Oxalate

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium oral capsule*
delayed release 40 mg

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Estradiol

Products Affected

- *estradiol transdermal patch twice weekly*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Estradiol

Products Affected

- *estradiol transdermal patch weekly*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Estrogel

Products Affected

- ESTROGEL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Eszopiclone

Products Affected

- *eszopiclone*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Euflexxa

Products Affected

- EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Evamist

Products Affected

- EVAMIST

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Evekeo

Products Affected

- EVEKEO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Evoxac

Products Affected

- EVOXAC

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Exalgo

Products Affected

- EXALGO ORAL TABLET ER 24 HOUR
ABUSE-DETERRENT 12 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Exalgo

Products Affected

- EXALGO 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Exelon

Products Affected

- EXELON TRANSDERMAL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Exforge

Products Affected

- EXFORGE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Exjade

Products Affected

- EXJADE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Extavia

Products Affected

- EXTAVIA SUBCUTANEOUS KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ezetimibe

Products Affected

- *ezetimibe*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Ezetimibe-Simvastatin

Products Affected

- *ezetimibe-simvastatin*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Fabior

Products Affected

- FABIOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fabrazyme

Products Affected

- FABRAZYME

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FaLessa

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Famciclovir

Products Affected

- *famciclovir oral tablet 125 mg, 250 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Famciclovir

Products Affected

- *famciclovir oral tablet 500 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Famvir

Products Affected

- FAMVIR ORAL TABLET 500 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fanapt

Products Affected

- FANAPT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fanapt Titration Pack

Products Affected

- FANAPT TITRATION PACK

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Farxiga

Products Affected

- FARXIGA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Faslodex

Products Affected

- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
100 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	9 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
12.5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
25 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	3 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Felodipine ER

Products Affected

- *felodipine er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Femring

Products Affected

- FEMRING

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Fenofibrate

Products Affected

- *fenofibrate oral capsule*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Fenofibrate

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Fenofibric Acid

Products Affected

- *fenofibric acid oral tablet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

FentaNYL

Products Affected

- *fentanyl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	20 patches Per 30 Days
Notes/References	Annual Review: 09/2016
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	120 tablets Per 30 Days
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Ferriprox

Products Affected

- FERRIPROX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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 - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Fiasp

Products Affected

- FIASP

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fiasp FlexTouch

Products Affected

- FIASP FLEXTOUCH

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fibricor

Products Affected

- FIBRICOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Finasteride

Products Affected

- *finasteride oral tablet 5 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Fiorinal/Codeine #3

Products Affected

- FIORINAL/CODEINE #3

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Firazyr

Products Affected

- FIRAZYR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Firmagon

Products Affected

- FIRMAGON

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Flebogamma DIF

Products Affected

- FLEBOGAMMA DIF

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Flolan

Products Affected

- FLOLAN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Flovent Diskus

Products Affected

- FLOVENT DISKUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Flovent HFA

Products Affected

- FLOVENT HFA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fluocinonide

Products Affected

- *fluocinonide external cream 0.05 %*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fluocinonide

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 60 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fluticasone-Salmeterol

Products Affected

- *fluticasone-salmeterol*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Fluvoxamine Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fluvoxamine Maleate

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fluvoxamine Maleate ER

Products Affected

- *fluvoxamine maleate er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Focalin

Products Affected

- FOCALIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Focalin XR

Products Affected

- FOCALIN XR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

FORA D10 2-in-1 Monitor

Products Affected

- FORA D10 2-IN-1 MONITOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FORA D15g 2-in-1 Monitor

Products Affected

- FORA D15G 2-IN-1 MONITOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FORA D20 2-in-1 Monitor

Products Affected

- FORA D20 2-IN-1 MONITOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Forteo

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION
600 MCG/2.4ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fosamax

Products Affected

- FOSAMAX ORAL TABLET 70 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Fosamax Plus D

Products Affected

- FOSAMAX PLUS D

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fragmin

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FreeStyle Flash System

Products Affected

- FREESTYLE FLASH SYSTEM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

FreeStyle Freedom Lite

Products Affected

- FREESTYLE FREEDOM LITE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

FreeStyle InsuLinx System

Products Affected

- FREESTYLE INSULINX SYSTEM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

FreeStyle InsuLinx Test

Products Affected

- FREESTYLE INSULINX TEST

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FreeStyle Lite Test

Products Affected

- FREESTYLE LITE TEST

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

FreeStyle Precision Neo Test

Products Affected

- FREESTYLE PRECISION NEO TEST

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

FreeStyle System

Products Affected

- FREESTYLE SYSTEM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

FreeStyle Test

Products Affected

- FREESTYLE TEST

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Frova

Products Affected

- FROVA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Frovatriptan Succinate

Products Affected

- *frovatriptan succinate*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fuzeon

Products Affected

- FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Fycompa

Products Affected

- FYCOMPA ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Gabapentin

Products Affected

- *gabapentin oral tablet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gabitril

Products Affected

- GABITRIL ORAL TABLET 12 MG
- GABITRIL ORAL TABLET 4 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gabril

Products Affected

- GABITRIL ORAL TABLET 16 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Gabril

Products Affected

- GABITRIL ORAL TABLET 2 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Galantamine Hydrobromide

Products Affected

- *galantamine hydrobromide*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Galantamine Hydrobromide ER

Products Affected

- *galantamine hydrobromide er*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Gammagard

Products Affected

- GAMMAGARD

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Gammagard S/D Less IgA

Products Affected

- GAMMAGARD S/D LESS IGA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gammaked

Products Affected

- GAMMAKED

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Gammaplex

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Gamunex-C

Products Affected

- GAMUNEX-C

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Gattex

Products Affected

- GATTEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

GaviLyte-C

Products Affected

- *gavilyte-c*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

GaviLyte-G

Products Affected

- *gavilyte-g*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Gelnique

Products Affected

- GELNIQUE TRANSDERMAL GEL 10 %

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gel-One

Products Affected

- GEL-ONE INTRA-ARTICULAR
PREFILLED SYRINGE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gelsyn-3

Products Affected

- GELSYN-3

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

GenVisc 850

Products Affected

- GENVISC 850

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Genvoya

Products Affected

- GENVOYA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Geodon

Products Affected

- GEODON ORAL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Giazo

Products Affected

- GIAZO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Gilenya

Products Affected

- GILENYA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Glassia

Products Affected

- GLASSIA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Glatopa

Products Affected

- *glatopa*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

GlucaGen Diagnostic

Products Affected

- GLUCAGEN DIAGNOSTIC

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

GlucaGen HypoKit

Products Affected

- GLUCAGEN HYPOKIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Glyxambi

Products Affected

- GLYXAMBI

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gralise

Products Affected

- GRALISE ORAL TABLET 300 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gralise

Products Affected

- GRALISE ORAL TABLET 600 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Gralise Starter

Products Affected

- GRALISE STARTER

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Granix

Products Affected

- GRANIX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

GuanFACINE HCl ER

Products Affected

- *guanfacine hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Haegarda

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/hereditary_angioedema.html
QL Criteria	16 kits Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Halobetasol Propionate

Products Affected

- *halobetasol propionate*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Harvoni

Products Affected

- HARVONI

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Heather

Products Affected

- *heather*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Helixate FS

Products Affected

- HELIXATE FS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Hemangeol

Products Affected

- HEMANGEOL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Hemofil M

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Hepsera

Products Affected

- HEPSERA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Hizentra

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

HM Nicotine

Products Affected

- *hm nicotine*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

HM Nicotine Polacrilex

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 one month of gabapentin. FOR RESTLESS LEG SYNDROME: A documented contraindication, intolerance, allergy, or failure of one month of pramipexole, or ropinirole.
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: February 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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 one month of gabapentin. FOR RESTLESS LEG SYNDROME:A documented contraindication, intolerance, allergy, or failure of one month of pramipexole, or ropinirole.
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: February 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

HP Acthar

Products Affected

- HP ACTHAR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Humate-P

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Humira

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Humira

Products Affected

- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Humira Pediatric Crohns Start

Products Affected

- HUMIRA PEDIATRIC CROHNS START
SUBCUTANEOUS PREFILLED SYRINGE
KIT 40 MG/0.8ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Humira Pen

Products Affected

- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Humira Pen-Crohns Starter

Products Affected

- HUMIRA PEN-CROHNS STARTER
SUBCUTANEOUS PEN-INJECTOR KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Humira Pen-Psoriasis Starter

Products Affected

- HUMIRA PEN-PSORIASIS STARTER
SUBCUTANEOUS PEN-INJECTOR KIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

HumuLIN 70/30

Products Affected

- HUMULIN 70/30

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

HumuLIN N

Products Affected

- HUMULIN N

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Hyalgan

Products Affected

- HYALGAN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Hycamtin

Products Affected

- HYCAMTIN ORAL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Hycet

Products Affected

- HYCET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Hymovis

Products Affected

- HYMOVIS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Hyqvia

Products Affected

- HYQVIA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Hysingla ER

Products Affected

- HYSINGLA ER

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Ibandronate Sodium

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ibrance

Products Affected

- IBRANCE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ibudone

Products Affected

- IBUDONE ORAL TABLET 10-200 MG
- *ibudone oral tablet 5-200 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 15 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 45 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Idelvion

Products Affected

- IDELVION

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/I/dhifa.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 08, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ilaris

Products Affected

- ILARIS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ilaris (150mg Delivered)

Products Affected

- ILARIS (150MG DELIVERED)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	4 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Imiquimod

Products Affected

- *imiquimod external*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Imitrex

Products Affected

- IMITREX NASAL SOLUTION 20
MG/ACT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Imitrex

Products Affected

- IMITREX NASAL SOLUTION 5 MG/ACT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Imitrex

Products Affected

- IMITREX ORAL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Imitrex

Products Affected

- IMITREX SUBCUTANEOUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Imitrex STATdose System

Products Affected

- IMITREX STATDOSE SYSTEM
SUBCUTANEOUS SOLUTION AUTO-
INJECTOR 6 MG/0.5ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Impavido

Products Affected

- IMPAVIDO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Increlex

Products Affected

- INCRELEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Inderal XL

Products Affected

- INDERAL XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 80 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Indomethacin

Products Affected

- *indomethacin oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Inflectra

Products Affected

- INFLECTRA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ingrezza

Products Affected

- INGREZZA ORAL CAPSULE 40 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ingrezza

Products Affected

- INGREZZA ORAL CAPSULE 80 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Inlyta

Products Affected

- INLYTA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

InnoPran XL

Products Affected

- INNOPRAN XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 120 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

InnoPran XL

Products Affected

- INNOPRAN XL ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 80 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Intelligence

Products Affected

- INTELENCE ORAL TABLET 100 MG, 25 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Intelligence

Products Affected

- INTELENCE ORAL TABLET 200 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Intrarosa

Products Affected

- INTRAROSA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Intron A

Products Affected

- INTRON A

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Intuniv

Products Affected

- INTUNIV

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: clonidine/sr, guanfacine, amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine, or Vyvanse
QL Criteria	1 TABS Per 1 DAY
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED
RELEASE 24 HOUR 1.5 MG, 3 MG, 9 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED
RELEASE 24 HOUR 6 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Invokamet

Products Affected

- INVOKAMET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Invokamet XR

Products Affected

- INVOKAMET XR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Invokana

Products Affected

- INVOKANA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Ipratropium Bromide

Products Affected

- *ipratropium bromide nasal*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Iprivask

Products Affected

- IPRIVASK

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Irbesartan

Products Affected

- *irbesartan*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Iressa

Products Affected

- IRESSA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Isentress

Products Affected

- ISENTRESS ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Isentress

Products Affected

- ISENTRESS ORAL TABLET CHEWABLE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Isentress HD

Products Affected

- ISENTRESS HD

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Itraconazole

Products Affected

- *itraconazole oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Ixinity

Products Affected

- IXINITY

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Jadenu

Products Affected

- JADENU

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Jadenu Sprinkle

Products Affected

- JADENU SPRINKLE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Jakafi

Products Affected

- JAKAFI

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Janumet

Products Affected

- JANUMET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Janumet XR

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Janumet XR

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Januvia

Products Affected

- JANUVIA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Jardiance

Products Affected

- JARDIANCE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Jentaduetto

Products Affected

- JENTADUETO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Jentaducto XR

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Jentaducto XR

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Jetrea

Products Affected

- JETREA INTRAVITREAL SOLUTION
0.375 MG/0.3ML

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Jevtana

Products Affected

- JEVTANA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Jinteli

Products Affected

- *jinteli*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Jolivette

Products Affected

- *jolivette*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Juxtapid

Products Affected

- JUXTAPID

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Kadian

Products Affected

- KADIAN ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Kadian

Products Affected

- KADIAN ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 100 MG, 20 MG, 30
MG, 50 MG, 60 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Kalbitor

Products Affected

- KALBITOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Kalydeco

Products Affected

- KALYDECO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kalydeco

Products Affected

- KALYDECO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kanuma

Products Affected

- KANUMA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kapvay

Products Affected

- KAPVAY ORAL TABLET EXTENDED
RELEASE 12 HOUR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	4 tabs Per 1 Day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kepivance

Products Affected

- KEPIVANCE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED
RELEASE 24 HOUR 500 MG

QL Criteria	6 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED
RELEASE 24 HOUR 750 MG

QL Criteria	4 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Ketoconazole

Products Affected

- *ketoconazole oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine ophthalmic*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Keveyis

Products Affected

- KEVEYIS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kevzara

Products Affected

- KEVZARA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Kineret

Products Affected

- KINERET SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kisqali 200 Dose

Products Affected

- KISQALI 200 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kisqali 400 Dose

Products Affected

- KISQALI 400 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kisqali 600 Dose

Products Affected

- KISQALI 600 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kisqali Femara 200 Dose

Products Affected

- KISQALI FEMARA 200 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kisqali Femara 600 Dose

Products Affected

- KISQALI FEMARA 600 DOSE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Kisqali.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 box Per 1 month
Notes/References	
Revision Date	Prior Authorization: April 05, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Koate

Products Affected

- KOATE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Koate-DVI

Products Affected

- KOATE-DVI

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kogenate FS

Products Affected

- KOGENATE FS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kogenate FS Bio-Set

Products Affected

- KOGENATE FS BIO-SET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kombiglyze XR

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Kombiglyze XR

Products Affected

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

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Korlym

Products Affected

- KORLYM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kovaltry

Products Affected

- KOVALTRY INTRAVENOUS SOLUTION
RECONSTITUTED 1000 UNIT, 2000
UNIT, 250 UNIT, 500 UNIT

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kroger Blood Glucose

Products Affected

- KROGER BLOOD GLUCOSE KIT W/DEVICE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Kroger Premium Blood Glucose

Products Affected

- KROGER PREMIUM BLOOD GLUCOSE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Krystexxa

Products Affected

- KRYSTEXXA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kuvan

Products Affected

- KUVAN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Kynamro

Products Affected

- KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Antilipidemic_Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Antilipidemic_Agents_HOFH.html
QL Criteria	4 SOLN Per 30 DAYSS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET
DISPERSIBLE 100 MG, 200 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET
DISPERSIBLE 25 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET
DISPERSIBLE 50 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LaMICtal XR

Products Affected

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

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 200 MG

QL Criteria	3 TB24 Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 250 MG,
300 MG

QL Criteria	2 TB24 Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LamoTRIGine

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

LamoTRIGine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LamoTRIGine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LamoTRIGine ER

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LamoTRIGine ER

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

LamoTRIGine ER

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

LamoTRIGine ER

Products Affected

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

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lantus

Products Affected

- LANTUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lantus SoloStar

Products Affected

- LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Larin Fe 1.5/30

Products Affected

- LARIN FE 1.5/30

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Latuda

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Latuda

Products Affected

- LATUDA ORAL TABLET 60 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Latuda

Products Affected

- LATUDA ORAL TABLET 80 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Leflunomide

Products Affected

- *leflunomide oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Lemtrada

Products Affected

- LEMTRADA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lenvima 10 MG Daily Dose

Products Affected

- LENVIMA 10 MG DAILY DOSE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	30 day supply Per 1 prescription
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Lenvima 18 MG Daily Dose

Products Affected

- LENVIMA 18 MG DAILY DOSE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lenvima 24 MG Daily Dose

Products Affected

- LENVIMA 24 MG DAILY DOSE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Lenvima 8 MG Daily Dose

Products Affected

- LENVIMA 8 MG DAILY DOSE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Lescol

Products Affected

- LESCOL ORAL CAPSULE 20 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lescol XL

Products Affected

- LESCOL XL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Letairis

Products Affected

- LETAIRIS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Leukine

Products Affected

- LEUKINE INTRAVENOUS

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Leuprolide Acetate

Products Affected

- *leuprolide acetate injection*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

LevETIRAcetam ER

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

LevETIRAcetam ER

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Levorphanol Tartrate

Products Affected

- *levorphanol tartrate oral*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Levulan Kerastick

Products Affected

- LEVULAN KERASTICK

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lexapro

Products Affected

- LEXAPRO ORAL TABLET 10 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lexapro

Products Affected

- LEXAPRO ORAL TABLET 20 MG
- LEXAPRO ORAL TABLET 5 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lialda

Products Affected

- LIALDA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lidocaine

Products Affected

- *lidocaine external ointment*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lidocaine

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Covered Uses	Neuropathic pain (i.e. post-herpetic neuralgia)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of neuropathic pain (i.e. post-herpetic neuralgia)
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 generic gabapentin or Lyrica
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lidocaine PAK

Products Affected

- *lidocaine pak*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Lidocaine-Tetracaine

Products Affected

- *lidocaine-tetracaine*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lidoderm

Products Affected

- LIDODERM

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Linezolid

Products Affected

- *linezolid oral suspension reconstituted*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Linezolid

Products Affected

- *linezolid oral tablet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Linzess

Products Affected

- LINZESS ORAL CAPSULE 145 MCG
- LINZESS ORAL CAPSULE 290 MCG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Linzess

Products Affected

- LINZESS ORAL CAPSULE 72 MCG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lipitor

Products Affected

- LIPITOR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lipofen

Products Affected

- LIPOFEN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Livalo

Products Affected

- LIVALO

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lofibra

Products Affected

- LOFIBRA ORAL CAPSULE 134 MG, 67 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lofibra

Products Affected

- LOFIBRA ORAL TABLET 54 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	80 tablets Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Lorcet HD

Products Affected

- LORCET HD

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Losartan Potassium

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lotronex

Products Affected

- LOTRONEX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lovastatin

Products Affected

- *lovastatin*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lovaza

Products Affected

- LOVAZA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lovenox

Products Affected

- LOVENOX

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION
0.01 %

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lumizyme

Products Affected

- LUMIZYME

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lunesta

Products Affected

- LUNESTA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Lupaneta Pack

Products Affected

- LUPANETA PACK

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lupron Depot (1-Month)

Products Affected

- LUPRON DEPOT (1-MONTH)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lupron Depot (3-Month)

Products Affected

- LUPRON DEPOT (3-MONTH)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lupron Depot (4-Month)

Products Affected

- LUPRON DEPOT (4-MONTH)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Lupron Depot (6-Month)

Products Affected

- LUPRON DEPOT (6-MONTH)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Lupron Depot-Ped (1-Month)

Products Affected

- LUPRON DEPOT-PED (1-MONTH)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Lupron Depot-Ped (3-Month)

Products Affected

- LUPRON DEPOT-PED (3-MONTH)

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lynparza

Products Affected

- LYNPARZA ORAL CAPSULE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lynparza

Products Affected

- LYNPARZA ORAL TABLET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Lysteda

Products Affected

- LYSTEDA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Lyza

Products Affected

- LYZA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Macugen

Products Affected

- MACUGEN

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Makena

Products Affected

- MAKENA

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Maprotiline HCl

Products Affected

- *maprotiline hcl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Marinol

Products Affected

- MARINOL

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	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 CAPS Per 1 DAYS
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Matzim LA

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Matzim LA

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mavyret

Products Affected

- MAVYRET

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Maxalt

Products Affected

- MAXALT

QL Criteria	12 tablets Per 30 DAYSS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Maxalt-MLT

Products Affected

- MAXALT-MLT

QL Criteria	12 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Meijer Blood Glucose

Products Affected

- MEIJER BLOOD GLUCOSE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Meijer Premium Blood Glucose

Products Affected

- MEIJER PREMIUM BLOOD GLUCOSE

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Mekinist

Products Affected

- MEKINIST ORAL TABLET 0.5 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mekinist

Products Affected

- MEKINIST ORAL TABLET 2 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Memantine HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Menostar

Products Affected

- MENOSTAR

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Meperidine HCl

Products Affected

- *meperidine hcl oral solution*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Meperidine HCl

Products Affected

- *meperidine hcl oral tablet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Mephyton

Products Affected

- MEPHYTON

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 1.2 gm*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mesalamine

Products Affected

- *mesalamine oral tablet delayed release 800 mg*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Metadate ER

Products Affected

- METADATE ER ORAL TABLET
EXTENDED RELEASE 20 MG

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Metaxalone

Products Affected

- *metaxalone oral tablet 400 mg*

QL Criteria	56 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methadone HCl

Products Affected

- *methadone hcl oral concentrate*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
 Formulary
 Last Update 12/2017
 Next Update

Methadone HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Methadone HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Methadone HCl

Products Affected

- *methadone hcl oral tablet*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

PA Criteria	Criteria Details
Other Criteria	
QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Methadone HCl Intensol

Products Affected

- *methadone hcl intensol*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
 Formulary
 Last Update 12/2017
 Next Update

Methamphetamine HCl

Products Affected

- *methamphetamine hcl*

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methergine

Products Affected

- METHERGINE ORAL

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Methylin

Products Affected

- METHYLIN ORAL SOLUTION 10
MG/5ML

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	30 soln Per 1 DAYS
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Methylin

Products Affected

- METHYLIN ORAL SOLUTION 5
MG/5ML

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	60 ML Per 1 Day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl

Products Affected

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

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

QL Criteria	6 tablet Per 1 Day
Notes/ References	Annual Review: 10/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Methylphenidate HCl ER

Products Affected

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

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 18 mg, 27 mg, 54 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 20 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 36 mg*

QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extended release 24 hour 36 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg*
- *methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule
extended release 24 hour 30 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Methylphenidate HCl ER (LA)

Products Affected

- *methylphenidate hcl er (la) oral capsule
extended release 24 hour 60 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 50 mg*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 200 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Metoprolol Succinate ER

Products Affected

- *metoprolol succinate er oral tablet extended release 24 hour 25 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mevacor

Products Affected

- MEVACOR ORAL TABLET 40 MG

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Miacalcin

Products Affected

- MIACALCIN INJECTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Miacalcin

Products Affected

- MIACALCIN NASAL

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
QL Criteria	1 bottle Per 30 Days
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Micardis

Products Affected

- MICARDIS

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Micardis HCT

Products Affected

- MICARDIS HCT

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Mimvey

Products Affected

- *mimvey*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Mirapex ER

Products Affected

- MIRAPEX ER

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Mircera

Products Affected

- MIRCERA INJECTION SOLUTION
PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2017/MISC/Erythroipoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mirtazapine

Products Affected

- *mirtazapine oral*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mitigare

Products Affected

- MITIGARE

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Monoclalte-P

Products Affected

- MONOCLATE-P INTRAVENOUS KIT
1000 UNIT, 1500 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mononine

Products Affected

- MONONINE INTRAVENOUS SOLUTION
RECONSTITUTED 1000 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Monovisc

Products Affected

- MONOVISC

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

QL Criteria	1 pack Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

MorphaBond ER

Products Affected

- MORPHABOND ER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Morphine Sulfate

Products Affected

- *morphine sulfate oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Mozobil

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Mozobil.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: October 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Multaq

Products Affected

- MULTAQ

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Mupirocin

Products Affected

- *mupirocin external*

QL Criteria	60 gram Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mupirocin Calcium

Products Affected

- *mupirocin calcium*

QL Criteria	60 gram Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Myalept

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.5 VIAL Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mydayis

Products Affected

- MYDAYIS

PA Criteria	Criteria Details
Covered Uses	Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 13 years and older
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
Age Restrictions	13 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Myobloc

Products Affected

- MYOBLOC INTRAMUSCULAR SOLUTION 2500 UNIT/0.5ML, 5000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Myorisan

Products Affected

- *myorisan oral capsule 10 mg, 20 mg, 40 mg* • MYORISAN ORAL CAPSULE 30 MG

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Myrbetriq

Products Affected

- MYRBETRIQ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Mytesi

Products Affected

- MYTESI

PA Criteria	Criteria Details
Covered Uses	Non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy
Exclusion Criteria	
Required Medical Information	Covered for adult members who have a documented diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month and who are currently stable on anti-retroviral therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of at least one anti-motility agent (loperamide, diphenoxylate/atropine, bismuth subsalicylate)
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: September 12, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Myzilra

Products Affected

- *myzilra*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Naglazyme

Products Affected

- NAGLAZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Namenda

Products Affected

- NAMENDA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Namenda Titration Pak

Products Affected

- NAMENDA TITRATION PAK

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Namenda XR

Products Affected

- NAMENDA XR

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Namzarin

Products Affected

- NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Namzarin

Products Affected

- NAMZARIC ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 14-10
MG, 28-10 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 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Naratriptan HCl

Products Affected

- *naratriptan hcl*

QL Criteria	9 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nasonex

Products Affected

- NASONEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Natpara

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ctg Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nerlynx

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Nerlynx.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nesina

Products Affected

- NESINA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Neulasta

Products Affected

- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Neupogen

Products Affected

- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Neupro

Products Affected

- NEUPRO

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Neurontin

Products Affected

- NEURONTIN ORAL CAPSULE

QL Criteria	6 cap Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Neurontin

Products Affected

- NEURONTIN ORAL TABLET

QL Criteria	6 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Neutek 2Tek Glucose/Pressure

Products Affected

- NEUTEK 2TEK GLUCOSE/PRESSURE

QL Criteria	1 meter Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nevirapine ER

Products Affected

- *nevirapine er oral tablet extended release 24 hour 100 mg*

QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nevirapine ER

Products Affected

- *nevirapine er oral tablet extended release 24 hour 400 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NexIUM

Products Affected

- NEXIUM ORAL CAPSULE DELAYED
RELEASE 40 MG

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

NexIUM

Products Affected

- NEXIUM ORAL PACKET

QL Criteria	1 pack Per 1 day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NexIUM 24HR

Products Affected

- NEXIUM 24HR

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nexplanon

Products Affected

- NEXPLANON

QL Criteria	1 implant Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Next Choice One Dose

Products Affected

- *next choice one dose*

QL Criteria	1 tablet Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nicoderm CQ

Products Affected

- NICODERM CQ

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nicorelief

Products Affected

- *nicorelief mouth/throat gum*

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Nicorette

Products Affected

- NICORETTE MOUTH/THROAT GUM

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nicotine

Products Affected

- *nicotine transdermal patch 24 hour*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nicotine Step 1

Products Affected

- *nicotine step 1*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nicotine Step 2

Products Affected

- *nicotine step 2*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Nicotine Step 3

Products Affected

- *nicotine step 3*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nicotrol

Products Affected

- NICOTROL

QL Criteria	3 boxes-504 crtrg Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nicotrol NS

Products Affected

- NICOTROL NS

QL Criteria	4 bottles Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nifediac CC

Products Affected

- *nifediac cc oral tablet extended release 24 hour 30 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nifedical XL

Products Affected

- *nifedical xl oral tablet extended release 24 hour 60 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NIFEdipine ER

Products Affected

- *nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NIFEdipine ER

Products Affected

- *nifedipine er oral tablet extended release 24 hour 60 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NIFEdipine ER Osmotic Release

Products Affected

- *nifedipine er osmotic release oral tablet*
extended release 24 hour 30 mg, 90 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NIFEdipine ER Osmotic Release

Products Affected

- *nifedipine er osmotic release oral tablet*
extended release 24 hour 60 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nikki

Products Affected

- NIKKI

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	3 capsules Per 28 days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 34 mg, 40 mg, 8.5 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hour 30 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nitroglycerin

Products Affected

- *nitroglycerin translingual solution*

QL Criteria	12 grams Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nitrostat

Products Affected

- NITROSTAT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of nitroglycerin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nityr

Products Affected

- NITYR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nora-BE

Products Affected

- *nora-be*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Norco

Products Affected

- NORCO

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Norditropin FlexPro

Products Affected

- NORDITROPIN FLEXPPO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Norlyroc

Products Affected

- NORLYROC

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Northera

Products Affected

- NORTHERA ORAL CAPSULE 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Northera

Products Affected

- NORTHERA ORAL CAPSULE 200 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/Northera.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Novoeight

Products Affected

- NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLIN 70/30

Products Affected

- NOVOLIN 70/30

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLIN 70/30 ReliOn

Products Affected

- NOVOLIN 70/30 RELION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLIN N

Products Affected

- NOVOLIN N

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLIN N ReliOn

Products Affected

- NOVOLIN N RELION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLIN R

Products Affected

- NOVOLIN R

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLIN R ReliOn

Products Affected

- NOVOLIN R RELION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLOG

Products Affected

- NOVOLOG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLOG FlexPen

Products Affected

- NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLOG Mix 70/30

Products Affected

- NOVOLOG MIX 70/30

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoLOG Mix 70/30 FlexPen

Products Affected

- NOVOLOG MIX 70/30 FLEXPEN
SUBCUTANEOUS SUSPENSION PEN-
INJECTOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

NovoLOG PenFill

Products Affected

- NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of one preferred alternative insulin, Humulin or Humalog
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NovoSeven RT

Products Affected

- NOVOSEVEN RT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Noxafil

Products Affected

- NOXAFIL ORAL TABLET DELAYED RELEASE

QL Criteria	93 TBEC Per 30 DAYSS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nucala

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/RESP/Interleukin Antagonist.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 injection Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nucynta

Products Affected

- NUCYNTA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 two of the following: morphine, oxycodone, hydromorphone
QL Criteria	6 tablets Per 1 day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Nucynta ER

Products Affected

- NUCYNTA ER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	FOR A DIAGNOSIS OF PAIN: A documented contraindication, intolerance, allergy, or failure of two of Butrans, Hysingla ER, or Oxycontin. FOR A DIAGNOSIS OF DIABETIC PERIPHERAL NEUROPATHY: A documented contraindication, intolerance, allergy, or failure of Cymbalta and Lyrica.
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Nuedexta

Products Affected

- NUEDEXTA

QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nuplazid

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/Nuplazid.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nutropin AQ NuSpin 10

Products Affected

- NUTROPIN AQ NUSPIN 10

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Nutropin AQ NuSpin 20

Products Affected

- NUTROPIN AQ NUSPIN 20

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nutropin AQ NuSpin 5

Products Affected

- NUTROPIN AQ NUSPIN 5

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NuvaRing

Products Affected

- NUVARING

QL Criteria	1 ring Per 28 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Nuvigil

Products Affected

- NUVIGIL

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Nuwiq

Products Affected

- NUWIQ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Nymalize

Products Affected

- NYMALIZE ORAL SOLUTION 60
MG/20ML

QL Criteria	135.2 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Ocaliva

Products Affected

- OCALIVA ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Primary_Biliary_Cholangitis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Primary_Biliary_Cholangitis.html
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Octagam

Products Affected

- OCTAGAM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Octreotide Acetate

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Odefsey

Products Affected

- ODEFSEY

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Odomzo

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Odomzo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

OLANZapine

Products Affected

- *olanzapine oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg*
- *olanzapine oral tablet dispersible*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

OLANZapine

Products Affected

- *olanzapine oral tablet 2.5 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Olmesartan Medoxomil

Products Affected

- *olmesartan medoxomil oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Olmesartan Medoxomil-HCTZ

Products Affected

- *olmesartan medoxomil-hctz*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Olmesartan-Amlodipine-HCTZ

Products Affected

- *olmesartan-amlodipine-hctz*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Olysio

Products Affected

- OLYSIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
QL Criteria	1 CAPS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Omnaris

Products Affected

- OMNARIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of two of the following: flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Omnitrope

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

OneTouch Ultra 2

Products Affected

- ONETOUCH ULTRA 2

QL Criteria	1 KIT Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

OneTouch Ultra Blue

Products Affected

- ONETOUCH ULTRA BLUE

QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

OneTouch Ultra Mini

Products Affected

- ONETOUCH ULTRA MINI

QL Criteria	1 KIT Per 365 DAYSS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

OneTouch Verio

Products Affected

- ONETOUCH VERIO IN VITRO STRIP

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

OneTouch Verio IQ System

Products Affected

- ONETOUCH VERIO IQ SYSTEM

QL Criteria	1 KIT Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Onfi

Products Affected

- ONFI ORAL TABLET 10 MG, 20 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Onglyza

Products Affected

- ONGLYZA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 1 month each of Januvia, Janumet, or Janumet XR; Tradjenta or Jentaducto; and generic alogliptin, alogliptin/pioglitazone, or alogliptin/metformin
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Onzetra Xsail

Products Affected

- ONZETRA XSAIL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of sumatriptan nasal spray
QL Criteria	1 kit Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Opana

Products Affected

- OPANA ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	4 tablets Per 1 day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 DAYS
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Oravig

Products Affected

- ORAVIG

QL Criteria	14 tablets Per 1 fill
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Orencia

Products Affected

- ORENCIA INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Orencia

Products Affected

- ORENCIA SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE 125 MG/ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
QL Criteria	4 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Orencia

Products Affected

- ORENCIA SUBCUTANEOUS SOLUTION
 PREFILLED SYRINGE 50 MG/0.4ML, 87.5
 MG/0.7ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Orencia ClickJect

Products Affected

- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Orenitram

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Orfadin

Products Affected

- ORFADIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Orkambi

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Orkambi

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

OrthoVisc

Products Affected

- ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Oseltamivir Phosphate

Products Affected

- *oseltamivir phosphate oral capsule*

QL Criteria	20 capsules Per 365 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Osphena

Products Affected

- OSPHENA

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Otezla

Products Affected

- OTEZLA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otezla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otezla.html
QL Criteria	2 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Otezla

Products Affected

- OTEZLA ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otezla.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otezla.html
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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/rxnnonmedicare/data/2017/MUSC/Otrexup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Oxaydo

Products Affected

- OXAYDO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 150 MG,
300 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 600 MG

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Oxybutynin Chloride

Products Affected

- *oxybutynin chloride oral tablet*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er oral tablet extended release 24 hour 5 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral concentrate 100 mg/5ml*
- *oxycodone hcl oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

OxyCODONE HCl

Products Affected

- *oxycodone hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Oxycodone-Acetaminophen

Products Affected

- *oxycodone-acetaminophen oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Oxycodone-Aspirin

Products Affected

- *oxycodone-aspirin oral tablet 4.8355-325 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	28 tablets Per 1 fill
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Oxymorphone HCl

Products Affected

- *oxymorphone hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

OxyMORphone HCl ER

Products Affected

- *oxymorphone hcl er*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release*
24 hour 1.5 mg, 3 mg, 6 mg

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release*
24 hour 9 mg

QL Criteria	1 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Pancreaze

Products Affected

- PANCREAZE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Creon and Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Paricalcitol

Products Affected

- *paricalcitol oral*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 10 mg, 20 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release*
24 hour 12.5 mg, 37.5 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release*
24 hour 25 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PARoxetine Mesylate

Products Affected

- *paroxetine mesylate*

QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Paxil

Products Affected

- PAXIL ORAL SUSPENSION

QL Criteria	30 ml Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Paxil

Products Affected

- PAXIL ORAL TABLET 10 MG, 20 MG

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Paxil

Products Affected

- PAXIL ORAL TABLET 30 MG, 40 MG

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Paxil CR

Products Affected

- PAXIL CR ORAL TABLET EXTENDED
RELEASE 24 HOUR 12.5 MG

QL Criteria	6 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Paxil CR

Products Affected

- PAXIL CR ORAL TABLET EXTENDED
RELEASE 24 HOUR 25 MG

QL Criteria	3 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Paxil CR

Products Affected

- PAXIL CR ORAL TABLET EXTENDED
RELEASE 24 HOUR 37.5 MG

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

PEG 3350/Electrolytes

Products Affected

- *peg 3350/electrolytes*

QL Criteria	4 liters Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PEG-3350/Electrolytes

Products Affected

- *peg-3350/electrolytes*

QL Criteria	4 liters Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pegasys

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pegasys ProClick

Products Affected

- PEGASYS PROCLICK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PegIntron

Products Affected

- PEGINTRON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Penlac

Products Affected

- PENLAC

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED
RELEASE 250 MG

QL Criteria	16 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED
RELEASE 500 MG

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Pentazocine-Naloxone HCl

Products Affected

- *pentazocine-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Percocet

Products Affected

- PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Perforomist

Products Affected

- PERFOROMIST

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent (Step Therapy will not apply to members who have a documented inability to use an inhaler)
QL Criteria	4 milliliters Per 1 day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pertzye

Products Affected

- PERTZYE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Creon and Zenpep
Notes/ References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Phenoxybenzamine HCl

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/antihypertensive_misc.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Picato

Products Affected

- PICATO EXTERNAL GEL 0.015 %

QL Criteria	3 unit dose tubes Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Picato

Products Affected

- PICATO EXTERNAL GEL 0.05 %

QL Criteria	2 unit dose tubes Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Pioglitazone HCl

Products Affected

- *pioglitazone hcl*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Pioglitazone HCl-Glimepiride

Products Affected

- *pioglitazone hcl-glimepiride*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-metformin hcl*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Plavix

Products Affected

- PLAVIX

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Plegridy

Products Affected

- PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
QL Criteria	28 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Plegridy

Products Affected

- PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK
SUBCUTANEOUS SOLUTION PEN-
INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
QL Criteria	1 kit Per 365 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK
SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Plexion Cleansing Cloth

Products Affected

- PLEXION CLEANSING CLOTH
EXTERNAL PAD

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic Retin-A
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Pomalyst

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pradaxa

Products Affected

- PRADAXA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Eliquis and Xarelto
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Praluent

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
QL Criteria	2 syringes Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er*

QL Criteria	1 TAB Per 1 DAILY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prasugrel HCl

Products Affected

- *prasugrel hcl*

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS) managed with percutaneous coronary intervention which includes unstable angina or non-ST elevation myocardial infarction or ST elevation myocardial infarction (MI)
Exclusion Criteria	History of Stroke or transient ischemic attack (TIA)
Required Medical Information	Member has a documented diagnosis of acute coronary syndrome (ACS) and is managed by percutaneous coronary intervention (PCI), which includes unstable angina, non-ST-elevation myocardial infarction (NSTEMI), or ST -elevation myocardial infarction (STEMI) managed with primary or delayed PCI and member has no prior history of stroke or transient ischemic attack (TIA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 22, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pravachol

Products Affected

- PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Precision PCx

Products Affected

- PRECISION PCX

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Precision PCX Plus Test

Products Affected

- PRECISION PCX PLUS TEST

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Precision Point of Care Test

Products Affected

- PRECISION POINT OF CARE TEST

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Precision QID Test

Products Affected

- PRECISION QID TEST

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Precision Sof-Tact Test

Products Affected

- PRECISION SOF-TACT TEST

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Precision Xtra Blood Glucose

Products Affected

- PRECISION XTRA BLOOD GLUCOSE

QL Criteria	300 strips Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prefest

Products Affected

- PREFEST

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Premarin

Products Affected

- PREMARIN ORAL

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Premphase

Products Affected

- PREMPHASE

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prempro

Products Affected

- PREMPRO

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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)
QL Criteria	2 tablets Per 1 Day
Notes/References	Annual Review: 02/2017

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Prezista

Products Affected

- PREZISTA ORAL SUSPENSION

QL Criteria	2 bottles Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prezista

Products Affected

- PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prezista

Products Affected

- PREZISTA ORAL TABLET 800 MG

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PriLOSEC OTC

Products Affected

- PRILOSEC OTC

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Privigen

Products Affected

- PRIVIGEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/ivig.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Procardia XL

Products Affected

- PROCARDIA XL ORAL TABLET
EXTENDED RELEASE 24 HOUR 30 MG

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Procardia XL

Products Affected

- PROCARDIA XL ORAL TABLET
EXTENDED RELEASE 24 HOUR 60 MG,
90 MG

QL Criteria	2 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

ProCentra

Products Affected

- PROCENTRA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	40 milliliters Per 1 day
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Procrit

Products Affected

- PROCIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Procysbi

Products Affected

- PROCYSBI ORAL CAPSULE DELAYED
RELEASE 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
QL Criteria	8 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Procysbi

Products Affected

- PROCYSBI ORAL CAPSULE DELAYED
RELEASE 75 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
QL Criteria	25 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prodigy AutoCode Blood Glucose

Products Affected

- PRODIGY AUTOCODE BLOOD GLUCOSE KIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYSS
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Profilnine

Products Affected

- PROFILNINE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Progesterone Micronized

Products Affected

- *progesterone micronized oral*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Prolastin-C

Products Affected

- PROLASTIN-C INTRAVENOUS
SOLUTION RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prolia

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Promacta

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Promacta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Promacta

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Promacta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Prometrium

Products Affected

- PROMETRIUM

QL Criteria	2 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Propafenone HCl ER

Products Affected

- *propafenone hcl er*

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Protopic

Products Affected

- PROTOPIC

PA Criteria	Criteria Details
Covered Uses	Atopic dermatitis, Vitiligo
Exclusion Criteria	
Required Medical Information	FOR PROTOPIC 0.1%: A documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or an adolescent 16 years of age or older with either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. FOR PROTOPIC 0.03%: A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months)(Note: requirement of a trial of topical corticosteroid is not required) or a documented diagnosis of atopic dermatitis (eczema) or vitiligo in an adult or child 2 years of age or older and either a documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, or a documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, or the treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid (triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment)
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: October 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Proventil HFA

Products Affected

- PROVENTIL HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Ventolin HFA and ProAir
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Provigil

Products Affected

- PROVIGIL

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Provigil

Products Affected

- PROVIGIL

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage). FOR OSAHS: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with 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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

PROzac

Products Affected

- PROZAC ORAL CAPSULE 10 MG

QL Criteria	1 cap Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

PROzac

Products Affected

- PROZAC ORAL CAPSULE 20 MG

QL Criteria	4 cap Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PROzac

Products Affected

- PROZAC ORAL CAPSULE 40 MG

QL Criteria	2 cap Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Prudoxin

Products Affected

- PRUDOXIN

QL Criteria	45 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Pulmicort Flexhaler

Products Affected

- PULMICORT FLEXHALER

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Asmanex and QVAR
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: November 30, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Pulmozyme

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 ampules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Qbrelis

Products Affected

- QBRELIS

PA Criteria	Criteria Details
Covered Uses	Hypertension, Heart Failure, Myocardial Infarction
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension (Approved only for ages 6 and older), Heart failure, or Myocardial Infarction AND must have a documented inability to swallow tablets/capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Qnasl

Products Affected

- QNASL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Qnasl Childrens

Products Affected

- QNASL CHILDRENS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Qudexy XR

Products Affected

- QUDEXY XR ORAL CAPSULE ER 24
HOUR SPRINKLE 100 MG, 25 MG, 50 MG

QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Qudexy XR

Products Affected

- QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 150 MG, 200 MG

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 100 mg, 50 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 300 mg, 400 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 300 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 400 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QUetiapine Fumarate ER

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 50 mg*

QL Criteria	6 tablets Per 1 Day
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QuilliChew ER

Products Affected

- QUILICHEW ER ORAL TABLET
CHEWABLE EXTENDED RELEASE 20
MG, 40 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

QuilliChew ER

Products Affected

- QUILICHEW ER ORAL TABLET
CHEWABLE EXTENDED RELEASE 30
MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Attention deficit hyperactivity disorder (ADHD)
Age Restrictions	For Quillivant Only- 17 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
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, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	12 milliliters Per 1 day
Notes/References	Annual Review: 09/2017
Revision Date	Prior Authorization: May 16, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

RA Nicotine

Products Affected

- *ra nicotine transdermal*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Gastroesophageal reflux disease, Complications related to GERD (e.g. esophageal strictures, Barrett's Esophagus), Peptic ulcer disease, Treatment and prevention of gastroduodenal ulcers associated with NSAIDs, Zollinger-Ellison Syndrome, or Helicobacter pylori eradication (Additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	Annual Review: 02/2017
Revision Date	Prior Authorization: November 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rasagiline Mesylate

Products Affected

- *rasagiline mesylate oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rasuvo

Products Affected

- RASUVO SUBCUTANEOUS SOLUTION
AUTO-INJECTOR 10 MG/0.2ML, 12.5
MG/0.25ML, 15 MG/0.3ML, 17.5
MG/0.35ML, 20 MG/0.4ML, 22.5
MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML,
7.5 MG/0.15ML

ST Criteria	<a href="http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otr
exup_Rasuvo.html">http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Otr exup_Rasuvo.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
QL Criteria	20 bottles Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rayaldee

Products Affected

- RAYALDEE

PA Criteria	Criteria Details
Covered Uses	Treatment of secondary hyperparathyroidism in adult patients with stage 3 or 4 chronic kidney disease (CKD)
Exclusion Criteria	Patients with stage 5 CKD or in patients with end stage renal disease (ESRD) on dialysis
Required Medical Information	A documented diagnosis of secondary hyperparathyroidism and Stage 3 or 4 chronic kidney disease (CKD) and serum total 25-hydroxyvitamin D level is less than 30 ng/mL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of calcitriol
QL Criteria	1 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Rayos

Products Affected

- RAYOS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of prednisone
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Razadyne

Products Affected

- RAZADYNE ORAL TABLET 4 MG, 8 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	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rebetol

Products Affected

- REBETOL ORAL SOLUTION

QL Criteria	5 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Rebif

Products Affected

- REBIF SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Rebif Rebidose

Products Affected

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rebif Rebidoose Titration Pack

Products Affected

- REBIF REBIDOSE TITRATION PACK
SUBCUTANEOUS SOLUTION AUTO-
INJECTOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Rebif Titration Pack

Products Affected

- REBIF TITRATION PACK
SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 syringes Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Recombinate

Products Affected

- RECOMBINATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rectiv

Products Affected

- RECTIV

QL Criteria	1 tube Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Regranex

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	Treatment of lower extremity diabetic neuropathic ulcers
Exclusion Criteria	Documentation that the patient has NONE of the following: Neoplasm(s) at the sites(s) of application, will not be using in pressure ulcers, venous stasis ulcers, or ischemic diabetic ulcers, exposed joints, tendons, ligaments, and bone (at application site), or will not be using in wounds that close by primary intention (such as suturing or gluing)
Required Medical Information	A documented diagnosis of diabetes with lower extremity neuropathic ulcers that extend into the subcutaneous tissue or beyond with adequate blood supply
Age Restrictions	16 years or older
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	NOTE: The safety and efficacy of treatment beyond 20 weeks have not been determined.
QL Criteria	30 grams Per 30 Days
Notes/References	
Revision Date	Prior Authorization: April 03, 2017 Step Therapy: August 25, 2015 Quantity Limits: November 06, 2017

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Relenza Diskhaler

Products Affected

- RELENZA DISKHALER

QL Criteria	40 disks Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Relistor

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain and documented concomitant use of opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.6 ML Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concomitant use of opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	0.4 ML Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Relpax

Products Affected

- RELPAX

QL Criteria	6 tablets Per 30 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Remeron

Products Affected

- REMERON

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Remeron SolTab

Products Affected

- REMERON SOLTAB

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Remicade

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Remicade.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Remicade.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Remodulin

Products Affected

- REMODULIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Repaglinide-Metformin HCl

Products Affected

- *repaglinide-metformin hcl*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Repatha

Products Affected

- REPATHA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS_K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS_K9.html
QL Criteria	2 units Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Repatha Pushtronex System

Products Affected

- REPATHA PUSHTRONEX SYSTEM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
QL Criteria	1 syringe Per 30 days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Repatha SureClick

Products Affected

- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCS K9.html
QL Criteria	2 units Per 28 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Requip XL

Products Affected

- REQUIP XL

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Rescula

Products Affected

- RESCULA

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: December 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Restoril

Products Affected

- RESTORIL ORAL CAPSULE 22.5 MG, 7.5 MG

QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Retin-A

Products Affected

- RETIN-A

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Retin-A Micro

Products Affected

- RETIN-A MICRO

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Retin-A Micro Pump

Products Affected

- RETIN-A MICRO PUMP

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris (including comedonal, cystic, nodular and papular acne), actinic keratoses with lesions, hypertrophic scars or keloids, keratosis follicularis (e.g., Darier's disease, Darier-White disease), facial flat warts, multiple flat warts (e.g., common warts, plantar warts)
Exclusion Criteria	
Required Medical Information	For members greater than 35 years old, the following criteria must be met: Documented diagnosis of acne vulgaris (includes comedonal, cystic, nodular & papular acne), or Documented diagnosis of actinic keratoses and lesions are on the face, or Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin, or • Documented diagnosis of hypertrophic scars or keloids AND intralesional injection of corticosteroids was ineffective or not tolerated, or Documented diagnosis of keratosis follicularis (Darier's disease, Darier-White disease), or Documented diagnosis of facial flat warts, or Documented diagnosis of multiple flat warts (includes common warts and plantar warts)
Age Restrictions	Prior authorization only applies for members greater than 35 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revatio

Products Affected

- REVATIO ORAL SUSPENSION
RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revatio

Products Affected

- REVATIO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
QL Criteria	3 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revlimid

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Rexulti

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Schizophrenia
Exclusion Criteria	
Required Medical Information	Documented diagnosis of major depressive disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	FOR MAJOR DEPRESSIVE DISORDER: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine). FOR SCHIZOPHRENIA: A documented contraindication, intolerance, allergy, or failure of one atypical generic antipsychotic (i.e. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine) and Latuda.
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 08/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: October 27, 2017 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 150 MG
- REYATAZ ORAL CAPSULE 300 MG

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 200 MG

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rhofade

Products Affected

- RHOFADE

QL Criteria	4 tubes Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

RiaSTAP

Products Affected

- RIASTAP

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Rias tap.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: November 17, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Rilutek

Products Affected

- RILUTEK

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Riluzole

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	Documented diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of alendronate 70mg
QL Criteria	1 tablet Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 30 mg, 5 mg*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 35 mg* *release*
- *risedronate sodium oral tablet delayed*

QL Criteria	4 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

RisperDAL

Products Affected

- RISPERDAL ORAL SOLUTION

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG

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 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 4 MG

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	4 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 0.5 MG
- RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET
DISPERSIBLE 3 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET
DISPERSIBLE 4 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

RisperiDONE

Products Affected

- *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *risperidone oral tablet dispersible 0.5 mg*
- *risperidone oral tablet dispersible 1 mg, 2 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

RisperiDONE

Products Affected

- *risperidone oral tablet 3 mg*
- *risperidone oral tablet dispersible 3 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

RisperiDONE

Products Affected

- *risperidone oral tablet 4 mg*
- *risperidone oral tablet dispersible 4 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

RisperiD ONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 0.5 MG, 1 MG, 2 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

RisperiD ONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 3 MG

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

RisperiD ONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET
DISPERSIBLE 4 MG

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Ritalin

Products Affected

- RITALIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	6 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 10 MG,
30 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 CAPS Per 1 DAYS
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 20 MG
- RITALIN LA ORAL CAPSULE
EXTENDED RELEASE 24 HOUR 40 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	Annual Review: 09/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rituxan

Products Affected

- RITUXAN INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Rituxan.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Rituxan.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rivastigmine

Products Affected

- *rivastigmine*

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rivastigmine Tartrate

Products Affected

- *rivastigmine tartrate*

PA Criteria	Criteria Details
Covered Uses	Alzheimer's Disease
Exclusion Criteria	
Required Medical Information	Documented diagnosis of mild, moderate, severe Alzheimer's Disease
Age Restrictions	less than 40 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rixubis

Products Affected

- RIXUBIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release*
24 hour 12 mg

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release*
24 hour 2 mg, 4 mg, 6 mg, 8 mg

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Roxicodone

Products Affected

- ROXICODONE ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Rozerem

Products Affected

- ROZEREM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of zolpidem, zaleplon, or eszopiclone
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 08/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Rubraca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: January 09, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ruconest

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rydapt

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Rydapt.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: June 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Rythmol SR

Products Affected

- RYTHMOL SR

QL Criteria	2 CP12 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Saizen

Products Affected

- SAIZEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Saizen Click.Easy

Products Affected

- SAIZEN CLICK.EASY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Samsca

Products Affected

- SAMSCA ORAL TABLET 15 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Samsca

Products Affected

- SAMSCA ORAL TABLET 30 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sancuso

Products Affected

- SANCUSO

QL Criteria	1 patch Per 1 month
Notes/ References	Annual Review: 10/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SandoSTATIN

Products Affected

- SANDOSTATIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SandoSTATIN LAR Depot

Products Affected

- SANDOSTATIN LAR DEPOT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Santyl

Products Affected

- SANTYL

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Saphris

Products Affected

- SAPHRIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication such as aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, or clozapine and Latuda
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Savaysa

Products Affected

- SAVAYSA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Eliquis and Xarelto
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Savella

Products Affected

- SAVELLA

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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Savella Titration Pack

Products Affected

- SAVELLA TITRATION PACK

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: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Seebri Neohaler

Products Affected

- SEEBRI NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Spiriva and Incruse Ellipta
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Selzentry

Products Affected

- SELZENTRY ORAL SOLUTION

QL Criteria	8 bottles Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Selzentry

Products Affected

- SELZENTRY ORAL TABLET 150 MG
- SELZENTRY ORAL TABLET 75 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Selzentry

Products Affected

- SELZENTRY ORAL TABLET 25 MG

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sensipar

Products Affected

- SENSIPAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/myalept.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Serevent Diskus

Products Affected

- SEREVENT DISKUS

QL Criteria	2 blisters Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 100 MG, 50 MG

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	3 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 200 MG

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	4 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 25 MG

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	6 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 300 MG
- SEROQUEL ORAL TABLET 400 MG

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 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: December 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: December 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Serostim

Products Affected

- SEROSTIM SUBCUTANEOUS
SOLUTION RECONSTITUTED 4 MG, 5
MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sharobel

Products Affected

- SHAROBEL

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Signifor.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 SOLN Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sildenafil Citrate

Products Affected

- *sildenafil citrate oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Siliq

Products Affected

- SILIQ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Siliq.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Siliq.html
QL Criteria	2 injections Per 1 month
Notes/References	
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Simponi

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi.html
QL Criteria	1 syringe Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Simponi Aria

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi_Aria.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi_Aria.html
QL Criteria	1 vial Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Simvastatin

Products Affected

- *simvastatin oral*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Singulair

Products Affected

- SINGULAIR ORAL TABLET
- SINGULAIR ORAL TABLET CHEWABLE

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Sirturo

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antimycobacterial_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	188 EA Per 365 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sivextro

Products Affected

- SIVEXTRO ORAL

QL Criteria	6 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Skyla

Products Affected

- SKYLA

QL Criteria	1 IUD Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

SM Nicotine

Products Affected

- *sm nicotine transdermal*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp* • *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Solia

Products Affected

- *solia*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Soliqua

Products Affected

- SOLIQUA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one of the following: Victoza, Byetta, Bydureon, Tanzeum, Trulicity, Adylixin, Lantus, Toujeo, Levemir, Tresiba, Basaglar
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/San_dostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sonata

Products Affected

- SONATA ORAL CAPSULE 10 MG

QL Criteria	2 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Sonata

Products Affected

- SONATA ORAL CAPSULE 5 MG

QL Criteria	3 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Soolantra

Products Affected

- SOOLANTRA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of any of the preferred topical generic alternatives, metronidazole or sulfacetamide sodium with sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Soriatane

Products Affected

- SORIATANE ORAL CAPSULE 10 MG, 17.5 MG, 25 MG

QL Criteria	2 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sovaldi

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Spiriva HandiHaler

Products Affected

- SPIRIVA HANDIHALER

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT

QL Criteria	1 inhaler Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sporanox

Products Affected

- SPORANOX ORAL CAPSULE

QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Sporanox Pulsepak

Products Affected

- SPORANOX PULSEPAK

QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	Annual Review: 09/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Spritam

Products Affected

- SPRITAM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of immediate release levitiracetam tablets
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Stelara

Products Affected

- STELARA INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Stelara

Products Affected

- STELARA SUBCUTANEOUS SOLUTION
PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html
QL Criteria	1 syringe Per 1 month
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Stiolto Respimat

Products Affected

- STIOLTO RESPIMAT

QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG, 60 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 100 MG,
80 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 14 days each of 3 of the following medications: amphetamine/dextroamphetamine/sr, dexamethylphenidate/sr, dextroamphetamine, methamphetamine, methylphenidate/er/sr, atomoxetine or Vyvanse
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Strensiq

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Stribild

Products Affected

- STRIBILD

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Striverdi Respimat

Products Affected

- STRIVERDI RESPIMAT

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disorder (COPD)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Chronic obstructive pulmonary disease (COPD)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Serevent
QL Criteria	1 inhaler Per 1 month
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3
MG

QL Criteria	2 films Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG

QL Criteria	3 films Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Other Criteria	<p>For additional quantities, the member must have a documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or the member is enrolled in a hospice program or meets hospice criteria, or the member is terminally ill, or the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. In addition, there must be documentation of one of the following: (1) A Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement (exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program), or (2) the member has current diagnosis of cancer(see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physician, and the member has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol), oxymorphone(Opana), hydromorphone(Dilaudid), oxycodone/apap(Percocet))</p>
ST Criteria	<p>A documented contraindication, intolerance, allergy, or failure of one week each of fentanyl transmucosal lozenge and two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)</p>
QL Criteria	<p>120 sprays Per 30 Days</p>
Notes/References	<p>Annual Review: 06/2017</p>
Revision Date	<p>Prior Authorization: October 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Sular

Products Affected

- SULAR ORAL TABLET EXTENDED
RELEASE 24 HOUR 17 MG, 34 MG, 8.5
MG

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

SulfaSALazine

Products Affected

- *sulfasalazine oral*

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Sulfazine

Products Affected

- *sulfazine*

QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

SUMAtriptan

Products Affected

- *sumatriptan nasal*

QL Criteria	3 nasal sprays Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

SUMatriptan Succinate

Products Affected

- *sumatriptan succinate oral*

QL Criteria	9 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

SUMatriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution*
6 mg/0.5ml

QL Criteria	8 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

SUMatriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml*

QL Criteria	2 boxes (4 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SUMatriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml*

QL Criteria	2 boxes Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SUMatriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill subcutaneous solution cartridge*

QL Criteria	2 boxes (4 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Supartz

Products Affected

- SUPARTZ INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Supartz FX

Products Affected

- SUPARTZ FX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Supprelin LA

Products Affected

- SUPPRELIN LA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sutent

Products Affected

- SUTENT ORAL CAPSULE 12.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
QL Criteria	4 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sutent

Products Affected

- SUTENT ORAL CAPSULE 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sutent

Products Affected

- SUTENT ORAL CAPSULE 37.5 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
QL Criteria	1 capsule Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Sylatron

Products Affected

- SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Symbicort

Products Affected

- SYMBICORT

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Symbyax

Products Affected

- SYMBYAX ORAL CAPSULE 12-25 MG,
12-50 MG, 6-25 MG, 6-50 MG

QL Criteria	1 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Revision Date	Prior Authorization: June 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
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 Step Therapy: November 06, 2017 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Synagis

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Synagis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Synalgos-DC

Products Affected

- SYNALGOS-DC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Synarel

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Syndros

Products Affected

- SYNDROS

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	4 bottles Per 1 month
Notes/References	
Revision Date	Prior Authorization: July 10, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Synera

Products Affected

- SYNERA

QL Criteria	10 patches Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Synjardy

Products Affected

- SYNJARDY

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Synjardy XR

Products Affected

- SYNJARDY XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 10-1000
MG, 12.5-1000 MG, 5-1000 MG

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Synjardy XR

Products Affected

- SYNJARDY XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 25-1000
MG

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Synribo

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Synvisc

Products Affected

- SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/viscosupplements.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Syprine

Products Affected

- SYPRINE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Taclonex

Products Affected

- TACLONEX EXTERNAL OINTMENT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one medium to high potency steroid indicated for patients condition.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Taclonex

Products Affected

- TACLONEX EXTERNAL SUSPENSION

QL Criteria	60 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid (triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, hydrocortisone valerate, or fluticasone propionate ointment)
Notes/ References	Annual Review: 06/2017
Revision Date	Prior Authorization: October 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Tafinlar

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	4 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tagrisso

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Tagrisso.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Take Action

Products Affected

- *take action*

QL Criteria	1 tablet Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Taltz

Products Affected

- TALTZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Taltz.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Taltz.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tamiflu

Products Affected

- TAMIFLU ORAL CAPSULE

QL Criteria	20 capsules Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Tamiflu

Products Affected

- TAMIFLU ORAL SUSPENSION
RECONSTITUTED 6 MG/ML

QL Criteria	1 bottle Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Tanzeum

Products Affected

- TANZEUM

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Victoza and Trulicity
QL Criteria	4 pens Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/ANEOPPL/Targretin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tazarotene

Products Affected

- *tazarotene external*

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris, plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Acne Vulgaris or plaque psoriasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tazorac

Products Affected

- TAZORAC

PA Criteria	Criteria Details
Covered Uses	Acne Vulgaris, plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Acne Vulgaris or plaque psoriasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Taztia XT

Products Affected

- *taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Taztia XT

Products Affected

- *taztia xt oral capsule extended release 24 hour 240 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tecfidera

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
QL Criteria	2 CPDR Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Tecfidera

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
QL Criteria	2 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Technivie

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
QL Criteria	2 EA Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Tekturna

Products Affected

- TEKTURNA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two preferred ACE-I or ARB . Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril), Univasc (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan) , Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tekturna HCT

Products Affected

- TEKTURNA HCT

ST Criteria	A documented contraindication, intolerance, allergy, or failure of two preferred ACE-I or ARB . Formulary Angiotensin Converting Enzyme Inhibitors (ACEI) & ACEI combinations include: Prinivil, Zestril (lisinopril), Lotensin/Lotensin HCT/Lotrel (benazepril), Vasotec (enalapril), Accupril (quinapril), Mavik (trandolapril), Univasc (moexipril). Formulary Angiotensin Receptor Blocker (ARB) & ARB combinations include: Cozaar/Hyzaar (losartan), Benicar/Benicar HCT (olmesartan), Micardis/Micardis HCT (telmisartan) , Diovan/Diovan HCT (valsartan), Avapro/Avalide (irbesartan), Atacand/Atacand HCT (candesartan), Teveten /Teveten HCT (eprosartan), Edarbi/Edarbyclor (azilsartan)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Telmisartan

Products Affected

- *telmisartan*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Telmisartan-Amlodipine

Products Affected

- *telmisartan-amlodipine*

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand, Avapro, Cozaar, Micardis
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Telmisartan-HCTZ

Products Affected

- *telmisartan-hctz*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Temazepam

Products Affected

- *temazepam oral capsule 22.5 mg, 7.5 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Temodar

Products Affected

- TEMODAR ORAL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Temovate

Products Affected

- TEMOVATE EXTERNAL CREAM

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Temozolomide

Products Affected

- *temozolomide*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Testim

Products Affected

- TESTIM

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%

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	10 grams Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Testosterone

Products Affected

- *testosterone transdermal gel 10 mg/act (2%)*

QL Criteria	4 grams Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	
QL Criteria	2.5 grams Per 1 Day

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Testosterone Cypionate

Products Affected

- *testosterone cypionate intramuscular solution 100 mg/ml*

QL Criteria	10 vials Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Testosterone Cypionate

Products Affected

- *testosterone cypionate intramuscular solution 200 mg/ml*

QL Criteria	10 ml Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 31, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 25 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: May 31, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

TGT Blood Glucose Monitoring

Products Affected

- TGT BLOOD GLUCOSE MONITORING

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

TGT Nicotine Step One

Products Affected

- *tgt nicotine step one*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

TGT Nicotine Step Three

Products Affected

- *tgt nicotine step three*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

TGT Nicotine Step Two

Products Affected

- *tgt nicotine step two*

QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Thalomid

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Thiola

Products Affected

- THIOLA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Thrive

Products Affected

- *thrive mouth/throat gum 2 mg*

QL Criteria	24 EA Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 2 mg*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 4 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tiazac

Products Affected

- TIAZAC ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 120 MG, 180 MG, 300
MG, 360 MG, 420 MG

QL Criteria	1 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Tiazac

Products Affected

- TIAZAC ORAL CAPSULE EXTENDED
RELEASE 24 HOUR 240 MG

QL Criteria	2 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Tirosint

Products Affected

- TIROSINT

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tivicay

Products Affected

- TIVICAY

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Tivicay

Products Affected

- TIVICAY

QL Criteria	2 TABS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Tivorbex

Products Affected

- TIVORBEX

QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Tobi

Products Affected

- TOBI

QL Criteria	56 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Tobi Podhaler

Products Affected

- TOBI PODHALER

QL Criteria	1 CAPS Per 28 DAYSS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tobramycin

Products Affected

- *tobramycin inhalation*

QL Criteria	10 ml Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Topamax Sprinkle

Products Affected

- TOPAMAX SPRINKLE

QL Criteria	4 CPSP Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Toprol XL

Products Affected

- TOPROL XL ORAL TABLET EXTENDED
RELEASE 24 HOUR 100 MG, 50 MG

QL Criteria	1.5 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Toprol XL

Products Affected

- TOPROL XL ORAL TABLET EXTENDED
RELEASE 24 HOUR 200 MG

QL Criteria	2 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Toprol XL

Products Affected

- TOPROL XL ORAL TABLET EXTENDED
RELEASE 24 HOUR 25 MG

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Toujeo SoloStar

Products Affected

- TOUJEO SOLOSTAR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Levemir and Tresiba
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Toviaz

Products Affected

- TOVIAZ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Vesicare and Myrbetriq and one generic (i.e. trospium, trospium ER, tolterodine, Tolterodine ER, oxybutynin, oxybutynin XL)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tracleer

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tradjenta

Products Affected

- TRADJENTA

QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

TraMADol HCl

Products Affected

- *tramadol hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

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	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

QL Criteria	30 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Trelegy Ellipta

Products Affected

- TRELEGY ELLIPTA

QL Criteria	2 blisters Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Trelstar Mixject

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tremfya

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Tremfya.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Tremfya.html
QL Criteria	1 injection Per 56 days
Notes/References	
Revision Date	Prior Authorization: August 02, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

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

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Notes/ References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Tretten

Products Affected

- TRETEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 capsules Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Tribenzor

Products Affected

- TRIBENZOR

ST Criteria	A documented contraindication, intolerance, allergy, or failure of amlodipine in combination with two of the following: Atacand HCT, Avalide, Hyzaar, Micardis HCT
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tricor

Products Affected

- TRICOR

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Triglide

Products Affected

- TRIGLIDE ORAL TABLET 160 MG

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Trilipix

Products Affected

- TRILIPIX

QL Criteria	1 CPDR Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Triptodur

Products Affected

- TRIPTODUR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Triumeq

Products Affected

- TRIUMEQ

QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Trokendi XR

Products Affected

- TROKENDI XR

QL Criteria	1 CP24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Trospium Chloride

Products Affected

- *trospium chloride*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Trospium Chloride ER

Products Affected

- *trospium chloride er*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

TRUEresult Blood Glucose

Products Affected

- TRUERESULT BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

TrueTrack Blood Glucose

Products Affected

- TRUETRACK BLOOD GLUCOSE KIT

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

TrueTrack Smart System

Products Affected

- TRUETRACK SMART SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of a physical limitation that makes utilization of a Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Lifescan product line, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years, 1 meter per year
Other Criteria	
QL Criteria	1 KIT Per 365 DAYs
Notes/References	
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Trulicity

Products Affected

- TRULICITY

QL Criteria	4 injections Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Truvada

Products Affected

- TRUVADA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviral_hiv.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tudorza Pressair

Products Affected

- TUDORZA PRESSAIR INHALATION
AEROSOL POWDER BREATH
ACTIVATED

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of Spiriva and Incruse Ellipta
QL Criteria	1 inhaler Per 30 fills
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

TussiCaps

Products Affected

- TUSSICAPS

QL Criteria	20 capsules Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Twynsta

Products Affected

- TWYNSTA

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 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tybost

Products Affected

- TYBOST

QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Tykerb

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tylenol with Codeine #3

Products Affected

- TYLENOL WITH CODEINE #3

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Tylenol with Codeine #4

Products Affected

- TYLENOL WITH CODEINE #4

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Tymlos

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
QL Criteria	1 pen Per 1 month
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tysabri

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tyvaso

Products Affected

- TYVASO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 SOLN Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Tyvaso Refill

Products Affected

- TYVASO REFILL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Tyvaso Starter

Products Affected

- TYVASO STARTER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Uceris

Products Affected

- UCERIS ORAL

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Asacol HD, Delzicol, Lialda or Pentasa
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Uceris

Products Affected

- UCERIS RECTAL

PA Criteria	Criteria Details
Covered Uses	Active mild to moderate ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of ACTIVE mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge, requiring induction of remission.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 canisters Per 1 month
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 11, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ulesfia

Products Affected

- ULESFIA

QL Criteria	3 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Uloric

Products Affected

- ULORIC

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Ultracet

Products Affected

- ULTRACET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Ultram

Products Affected

- ULTRAM

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Ultravate

Products Affected

- ULTRAVATE EXTERNAL LOTION

QL Criteria	120 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Uptravi

Products Affected

- UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Uptravi

Products Affected

- UPTRAVI ORAL TABLET 200 MCG PACK
- UPTRAVI ORAL TABLET THERAPY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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	
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 07/2017
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Valchlor

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 GM Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Valcyte

Products Affected

- VALCYTE ORAL SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Valcyte

Products Affected

- VALCYTE ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/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 EA Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl oral solution reconstituted*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1000 ML Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	102 TABS Per 30 DAYSS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Valsartan

Products Affected

- *valsartan*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Valsartan-Hydrochlorothiazide

Products Affected

- *valsartan-hydrochlorothiazide*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vantas

Products Affected

- VANTAS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Varubi

Products Affected

- VARUBI ORAL

QL Criteria	4 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Vascepa

Products Affected

- VASCEPA ORAL CAPSULE 0.5 GM

QL Criteria	8 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vascepa

Products Affected

- VASCEPA ORAL CAPSULE 1 GM

QL Criteria	4 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Veletri

Products Affected

- VELETRI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Veltassa

Products Affected

- VELTASSA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Veltassa.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 packet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Veltin

Products Affected

- VELTIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vemlidy

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Vemlidy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/Vemlidy.html
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: December 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 10 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	40 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 50 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venclexta Starting Pack

Products Affected

- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Venclexta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 pack Per 28 days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

QL Criteria	5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hour 225 mg*

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ventavis

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: December 22, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Verdrocet

Products Affected

- VERDROCET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Versacloz

Products Affected

- VERSACLOZ

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Clozaril tablets
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Verzenio.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: November 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

VESicare

Products Affected

- VESICARE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one preferred generic (i.e. trospium, trospium ER, tolterodine, tolterodine ER, oxybutynin)
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Viberzi

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Covered Uses	Diarrhea-predominant irritable bowel syndrome (IBS)
Exclusion Criteria	No known or suspected history of any of the following: does not have a gallbladder, diagnosis of pancreatitis, diagnosis of alcoholism, member drinks more than 3 alcoholic beverages/day, severe (Child-Pugh C) hepatic impairment, or anatomic or biochemical abnormalities of the gastrointestinal tract (e.g., biliary duct obstruction, sphincter of Oddi dysfunction, or severe constipation)
Required Medical Information	A documented diagnosis of diarrhea-predominant irritable bowel syndrome (IBS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	Annual Review: 10/2017
Revision Date	Prior Authorization: April 27, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Vicodin

Products Affected

- *vicodin oral tablet 5-300 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Vicodin ES

Products Affected

- *vicodin es oral tablet 7.5-300 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Vicodin HP

Products Affected

- *vicodin hp oral tablet 10-300 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Victoza

Products Affected

- VICTOZA SUBCUTANEOUS SOLUTION
PEN-INJECTOR

QL Criteria	1 box-2 or 3 pens Per 1 month
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Viekira Pak

Products Affected

- VIEKIRA PAK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Viekira XR

Products Affected

- VIEKIRA XR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Vigabatrin

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Viibryd

Products Affected

- VIIBRYD ORAL TABLET

QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 05/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vimizim

Products Affected

- VIMIZIM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vimpat

Products Affected

- VIMPAT ORAL SOLUTION

QL Criteria	40 ML Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vimpat

Products Affected

- VIMPAT ORAL TABLET

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Viokace

Products Affected

- VIOKACE

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Creon and Zenpep
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Viorele

Products Affected

- *viorele*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Viramune XR

Products Affected

- VIRAMUNE XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 100 MG

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Viramune XR

Products Affected

- VIRAMUNE XR ORAL TABLET
EXTENDED RELEASE 24 HOUR 400 MG

QL Criteria	1 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Viread

Products Affected

- VIREAD ORAL TABLET

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vistogard

Products Affected

- VISTOGARD

QL Criteria	20 packs Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Vivlodex

Products Affected

- VIVLODEX

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two generic non steroidal anti-inflammatory drugs
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vogelxo

Products Affected

- VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment
Exclusion Criteria	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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month of Androgel 1.62%
QL Criteria	10 grams Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
 Formulary
 Last Update 12/2017
 Next Update

Vogelxo Pump

Products Affected

- VOGELXO PUMP

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%

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

QL Criteria	10 grams Per 1 Day
Notes/ References	Annual Review: 02/2017
Revision Date	Prior Authorization: May 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Voltaren

Products Affected

- VOLTAREN TRANSDERMAL

QL Criteria	200 GM Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vonvendi

Products Affected

- VONVENDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Votrient

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vpriv

Products Affected

- VPRIV

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 1.5 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
QL Criteria	4 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 3 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
QL Criteria	2 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE THERAPY
PACK

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one generic medication (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) plus Latuda
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Vytorin

Products Affected

- VYTORIN

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic simvastatin in combination with generic ezetimibe, or generic ezetimibe-simvastatin
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Vyvanse

Products Affected

- VYVANSE

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Vyvanse

Products Affected

- VYVANSE

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Wellbutrin SR

Products Affected

- WELLBUTRIN SR

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Xadago

Products Affected

- XADAGO

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease (PD) experiencing "off" episodes
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Parkinson's disease and concurrent use of levodopa/carbidopa
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of rasagaline or selegiline
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: June 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xalatan

Products Affected

- XALATAN

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	
Revision Date	Prior Authorization: December 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xanax XR

Products Affected

- XANAX XR

QL Criteria	2 TB24 Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Xatmep

Products Affected

- XATMEP

PA Criteria	Criteria Details
Covered Uses	Treatment of acute lymphoblastic leukemia (ALL) or polyarticular juvenile idiopathic arthritis (pJIA) in pediatric patients
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Acute Lymphoblastic Leukemia (ALL) in a pediatric patient (18 years and younger) as part of a multi-phase, combination chemotherapy maintenance regimen or a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA) in pediatric patients (18 years and younger) who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs). Regardless of diagnosis, the patient must have a documented inability to swallow tablets/capsules.
Age Restrictions	Approved for those 18 years of age or younger
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: July 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xeljanz

Products Affected

- XELJANZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xeljanz XR

Products Affected

- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xeloda

Products Affected

- XELODA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xenazine

Products Affected

- XENAZINE ORAL TABLET 12.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 31, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xenazine

Products Affected

- XENAZINE ORAL TABLET 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 31, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xeomin

Products Affected

- XEOMIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Xermelo.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: April 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 200 MG

QL Criteria	9 tablets Per 1 fill
Notes/ References	Annual Review: 04/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea.
Exclusion Criteria	
Required Medical Information	FOR HEPATIC ENCEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/References	Annual Review: 04/2017
Revision Date	Prior Authorization: November 29, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open 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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Xigduo XR

Products Affected

- XIGDUO XR ORAL TABLET EXTENDED
RELEASE 24 HOUR 5-1000 MG

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Xodol

Products Affected

- XODOL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
QL Criteria	120 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/RESP/Xolair.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/RESP/Xolair.html
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xopenex HFA

Products Affected

- XOPENEX HFA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Ventolin HFA and ProAir
QL Criteria	2 inhalers Per 1 fill
Notes/ References	Annual Review: 03/2017
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xtampza ER

Products Affected

- XTAMPZA ER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	
Required Medical Information	<p>(1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months.</p>
Age Restrictions	
Prescriber Restrictions	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	2 capsules Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Xtandi

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xulane

Products Affected

- XULANE

QL Criteria	1 box (3 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Xultophy

Products Affected

- XULTOPHY

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one of the following: Victoza, Byetta, Bydureon, Tanzeum, Trulicity, Adylixin, Lantus, Toujeo, Levemir, Tresiba, Basaglar
QL Criteria	5 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xuriden

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 packets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xylon

Products Affected

- XYLON

QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Xyntha

Products Affected

- XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Xyntha Solofuse

Products Affected

- XYNTHA SOLOFUSE INTRAVENOUS
KIT 3000 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/cataplaxy-xyrem.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Yervoy

Products Affected

- YERVOY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/yervoy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zafirlukast

Products Affected

- *zafirlukast*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Zaleplon

Products Affected

- *zaleplon*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zarxio

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/G-CSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zavesca

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: January 11, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zegerid OTC

Products Affected

- ZEGERID OTC

QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zejula

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Zejula.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: May 09, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	8 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Zemaira

Products Affected

- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zembrace SymTouch

Products Affected

- ZEMBRACE SYMTOUCH

ST Criteria	A documented contraindication, intolerance, allergy, or failure of generic Imitrex injection
QL Criteria	8 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zenatane

Products Affected

- *zenatane oral capsule 10 mg, 20 mg, 40 mg*

QL Criteria	2 capsules Per 1 Day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zenatane

Products Affected

- ZENATANE ORAL CAPSULE 30 MG

QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zenzedi

Products Affected

- ZENZEDI ORAL TABLET 10 MG, 5 MG

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zepatier

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zetia

Products Affected

- ZETIA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of ezetimibe
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zetonna

Products Affected

- ZETONNA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of 2 weeks of flunisolide or mometasone and either OTC Nasacort 24HR or Flonase OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ziana

Products Affected

- ZIANA

ST Criteria	A documented contraindication, intolerance, allergy, or failure of Epiduo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zileuton ER

Products Affected

- *zileuton er*

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zinbryta

Products Affected

- ZINBRYTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html
QL Criteria	1 injection Per 30 Days
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zioptan

Products Affected

- ZIOPTAN

PA Criteria	Criteria Details
Covered Uses	open-angle glaucoma, ocular hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of glaucoma or ocular hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one week of latanoprost and one week of Travatan Z
Notes/References	Annual Review: 03/2017
Revision Date	Prior Authorization: December 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Ziprasidone HCl

Products Affected

- *ziprasidone hcl*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zocor

Products Affected

- ZOCOR

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

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	

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PA Criteria	Criteria Details
Coverage Duration	Length of Therapy; see required medical information
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of two preferred alternatives which include Hysingla ER, Embeda and Oxycontin
QL Criteria	2 capsules Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: September 06, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
 Last Update 12/2017
 Next Update

Zoladex

Products Affected

- ZOLADEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: February 20, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zoledronic Acid

Products Affected

- *zoledronic acid intravenous concentrate*
- *zoledronic acid intravenous solution*

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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/ANEOPPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPPL/Antineoplastics.html
QL Criteria	4 capsules Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 2.5 mg*

QL Criteria	6 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 5 mg*

QL Criteria	3 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet dispersible 2.5 mg*

QL Criteria	6 tablets Per 30 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet dispersible 5 mg*

QL Criteria	30 tablet Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 100 MG

QL Criteria	2 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 25 MG

QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 50 MG

QL Criteria	1.5 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate oral*

QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zometa

Products Affected

- ZOMETA INTRAVENOUS
CONCENTRATE

ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zomig

Products Affected

- ZOMIG NASAL SOLUTION 5 MG

QL Criteria	1 box (6 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zomig

Products Affected

- ZOMIG ORAL

QL Criteria	3 tablets Per 30 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zomig ZMT

Products Affected

- ZOMIG ZMT

QL Criteria	3 tablets Per 30 dayss
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zonalon

Products Affected

- ZONALON

QL Criteria	45 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zontivity

Products Affected

- ZONTIVITY

PA Criteria	Criteria Details
Covered Uses	Reduction of the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD)
Exclusion Criteria	Do not use in patients with history of stroke, history of transient ischemic attack (TIA), or history of intracranial hemorrhage (ICH), or active pathological bleeding
Required Medical Information	Documented diagnosis or history of myocardial infarction (MI) or peripheral arterial disease (PAD) and concurrent use of aspirin or clopidogrel.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/References	Annual Review: 06/2017
Revision Date	Prior Authorization: July 19, 2017 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zorbtive

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zorvolex

Products Affected

- ZORVOLEX

QL Criteria	3 CAPS Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET
SUBLINGUAL 0.7-0.18 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET
SUBLINGUAL 1.4-0.36 MG, 11.4-2.9 MG,
2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG

ST Criteria	A documented contraindication, intolerance, allergy, or failure of one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zurampic

Products Affected

- ZURAMPIC

PA Criteria	Criteria Details
Covered Uses	Treatment of hyperuricemia associated with gout
Exclusion Criteria	
Required Medical Information	A documented diagnosis of gout, and will be used in combination with a xanthine oxidase inhibitor (allopurinol OR febuxostat)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented contraindication, intolerance, allergy, or failure of allopurinol or febuxostat
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: October 04, 2017 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zyban

Products Affected

- ZYBAN

QL Criteria	2 tablet Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 CAP Per 1 DAYS
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary
Last Update 12/2017
Next Update

Zyflo

Products Affected

- ZYFLO

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zyflo CR

Products Affected

- ZYFLO CR

QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ZyPREXA

Products Affected

- ZYPREXA ORAL TABLET 10 MG, 15 MG, 20 MG, 7.5 MG
- ZYPREXA ORAL TABLET 5 MG

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	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ZyPREXA

Products Affected

- ZYPREXA ORAL TABLET 2.5 MG

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 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

ZyPREXA Zydys

Products Affected

- ZYPREXA ZYDIS

ST Criteria	A documented contraindication, intolerance, allergy, or failure of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, paliperidone er, clozapine, or Latuda
QL Criteria	1 tabs Per 1 DAYS
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zytiga

Products Affected

- ZYTIGA ORAL TABLET 250 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zytiga

Products Affected

- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/References	
Revision Date	Prior Authorization: September 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

Zyvox

Products Affected

- ZYVOX ORAL SUSPENSION
RECONSTITUTED

QL Criteria	1 bottle Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

Zyvox

Products Affected

- ZYVOX ORAL TABLET

QL Criteria	28 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary
Last Update 12/2017
Next Update

Index

ABILIFY ORAL TABLET.....	1	ADDERALL.....	43
ABSTRAL.....	3	ADDERALL XR.....	44
<i>acamprosate calcium</i>	5	<i>adefovir dipivoxil</i>	45
ACCOLATE.....	6	ADEMPAS.....	46
ACCU-CHEK AVIVA PLUS.....	7	ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/DOSE, 250-50 MCG/DOSE.....	47
ACCU-CHEK COMPACT PLUS CARE.....	8	ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 500-50 MCG/DOSE.....	48
ACCU-CHEK MULTICLIX LANCET DEV.....	9	ADVAIR HFA.....	49
ACCU-CHEK NANO SMARTVIEW...	10	ADVATE.....	50
<i>acetaminophen-codeine #2</i>	15	ADVOCATE DUO DEVICE.....	51
<i>acetaminophen-codeine #3</i>	17	<i>adynovate</i>	52
<i>acetaminophen-codeine #4</i>	19	ADYPHREN.....	53
<i>acetaminophen-codeine oral solution</i>	11	ADYPHREN AMP II.....	54
<i>acetaminophen-codeine oral tablet</i>	13	ADYPHREN II.....	55
ACIPHEX.....	21	ADZENYS XR-ODT.....	56
ACIPHEX SPRINKLE.....	23	AEROSPAN.....	57
<i>acitretin</i>	25	<i>afeditab cr oral tablet extended release 24 hour 30 mg</i>	58
ACTEMRA INTRAVENOUS.....	26	<i>afeditab cr oral tablet extended release 24 hour 60 mg</i>	59
ACTEMRA SUBCUTANEOUS.....	27	AFINITOR.....	60
ACTIMMUNE.....	28	AFINITOR DISPERZ.....	61
ACTIQ.....	29	AFREZZA INHALATION POWDER 12 UNIT, 8 UNIT.....	62
ACTIVELLA.....	31	AFREZZA INHALATION POWDER 4 & 8 & 12 UNIT, 4 (30) & 8 (60) UNIT, 4 (90) & 8 (90) UNIT, 4 UNIT, 8 (60)& 12 (30) UNIT.....	63
ACTONEL ORAL TABLET 150 MG...	32	AFREZZA INHALATION POWDER 4 (60) & 8 (30) UNIT.....	64
ACTONEL ORAL TABLET 30 MG.....	33	AFSTYLA.....	65
ACTONEL ORAL TABLET 35 MG.....	34	AGAMATRIX PRESTO.....	66
ACTONEL ORAL TABLET 5 MG.....	33	AIRDUO RESPICLICK 113/14.....	67
ACTOPLUS MET.....	35	AIRDUO RESPICLICK 232/14.....	68
ACTOPLUS MET XR.....	36	AIRDUO RESPICLICK 55/14.....	69
ACTOS.....	37		
ACZONE.....	38		
ADAGEN.....	39		
ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 90 MG.....	40		
ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG.....	41		
ADCIRCA.....	42		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

AKYNZEO.....	70	ANDROGEL PUMP	
ALBENZA.....	71	TRANSDERMAL GEL 20.25	
ALDARA.....	72	MG/ACT (1.62%).....	113
ALDURAZYME.....	73	ANDROGEL TRANSDERMAL GEL	
ALECENSA.....	74	20.25 MG/1.25GM (1.62%).....	105
<i>alendronate sodium oral tablet 10 mg, 40</i>		ANDROGEL TRANSDERMAL GEL	
<i>mg, 5 mg.....</i>	75	25 MG/2.5GM (1%).....	107
<i>alendronate sodium oral tablet 35 mg.....</i>	76	ANDROGEL TRANSDERMAL GEL	
<i>alfuzosin hcl er.....</i>	77	40.5 MG/2.5GM (1.62%).....	109
ALINIA ORAL SUSPENSION		ANDROGEL TRANSDERMAL GEL	
RECONSTITUTED.....	78	50 MG/5GM (1%).....	111
ALINIA ORAL TABLET.....	79	ANORO ELLIPTA.....	115
<i>almotriptan malate.....</i>	80	ANTARA ORAL CAPSULE 30 MG,	
<i>alogliptin benzoate.....</i>	81	90 MG.....	116
<i>alogliptin-metformin hcl.....</i>	82	ANZEMET ORAL.....	117
<i>alogliptin-pioglitazone.....</i>	83	<i>apap-caff-dihydrocodeine oral capsule.....</i>	118
<i>alose tron hcl.....</i>	84	APIDRA.....	120
ALPHANATE/VWF		APIDRA SOLOSTAR	
COMPLEX/HUMAN.....	85	SUBCUTANEOUS SOLUTION PEN-	
ALPHANINE SD.....	86	INJECTOR.....	121
<i>alprazolam er.....</i>	87	<i>aprepitant oral capsule 125 mg, 40 mg, 80</i>	
<i>alprazolam xr.....</i>	88	<i>mg.....</i>	122
ALPROLIX.....	89	<i>aprepitant oral capsule 80 & 125 mg.....</i>	123
ALTOPREV.....	90	APRISO.....	124
ALUNBRIG.....	91	APTENSIO XR.....	125
ALVESCO.....	92	APTIOM ORAL TABLET 200 MG,	
AMBIEN CR.....	95	600 MG.....	126
AMBIEN ORAL TABLET 10 MG.....	93	APTIOM ORAL TABLET 400 MG,	
AMBIEN ORAL TABLET 5 MG.....	94	800 MG.....	127
AMERGE.....	96	ARALAST NP INTRAVENOUS	
AMITIZA.....	97	SOLUTION RECONSTITUTED 1000	
<i>amlodipine besylate-valsartan.....</i>	98	MG, 500 MG.....	128
<i>amlodipine-olmesartan.....</i>	99	ARANESP (ALBUMIN FREE)	
<i>amlodipine-valsartan-hctz.....</i>	100	INJECTION SOLUTION 100	
<i>amnesteem.....</i>	101	MCG/ML, 200 MCG/ML, 25	
<i>amphetamine-dextroamphet er.....</i>	102	MCG/ML, 300 MCG/ML, 40	
<i>amphetamine-dextroamphetamine.....</i>	103	MCG/ML, 60 MCG/ML.....	129
AMPYRA.....	104		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

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.....	129	ATELVIA.....	157
ARAVA.....	130	<i>atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg.....</i>	158
ARCALYST.....	131	<i>atomoxetine hcl oral capsule 100 mg, 80 mg.....</i>	159
ARCAPTA NEOHALER.....	132	<i>atorvastatin calcium oral.....</i>	160
ARICEPT.....	133	ATRIPLA.....	161
<i>aripiprazole oral solution.....</i>	134	ATROVENT HFA.....	162
<i>aripiprazole oral tablet.....</i>	135	AUBAGIO.....	163
<i>aripiprazole oral tablet dispersible.....</i>	135	AUSTEDO.....	164
ARIXTRA.....	136	AVALIDE ORAL TABLET 150-12.5 MG.....	165
<i>armodafinil oral tablet 150 mg.....</i>	137	AVALIDE ORAL TABLET 300-12.5 MG.....	166
<i>armodafinil oral tablet 200 mg, 250 mg... armodafinil oral tablet 50 mg.....</i>	137 139	AVANDIA ORAL TABLET 2 MG, 4 MG.....	167
ARMONAIR RESPICLICK 113.....	141	AVAPRO.....	168
ARMONAIR RESPICLICK 232.....	142	<i>avita external cream.....</i>	169
ARMONAIR RESPICLICK 55.....	143	<i>avita external gel.....</i>	171
ARNUITY ELLIPTA.....	144	AVODART.....	173
ARYMO ER.....	145	AVONEX.....	174
ARZERRA.....	147	AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT.....	175
ASACOL HD.....	148	AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT.....	176
<i>ascomp-codeine.....</i>	149	AXERT.....	177
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG.....	151	AZILECT.....	178
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 1 MG.....	152	AZOR.....	179
ATACAND HCT ORAL TABLET 16- 12.5 MG.....	155	AZULFIDINE.....	180
ATACAND HCT ORAL TABLET 32- 12.5 MG, 32-25 MG.....	156	AZULFIDINE EN-TABS.....	181
ATACAND ORAL TABLET 16 MG... ATACAND ORAL TABLET 32 MG... ATACAND ORAL TABLET 4 MG, 8 MG.....	153 154 153	BACTROBAN EXTERNAL CREAM..... <i>balsalazide disodium.....</i>	182 183
		BANZEL ORAL TABLET.....	184
		BARACLUDE ORAL TABLET.....	185
		BASAGLAR KWIKPEN.....	186
		BAXDELA ORAL.....	187
		BAYER CONTOUR LINK MONITOR.....	189
		BAYER CONTOUR MONITOR KIT.....	190

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

BAYER CONTOUR NEXT EZ.....	191	BROVANA.....	224
BAYER CONTOUR NEXT LINK.....	192	<i>budesonide inhalation</i>	225
BAYER CONTOUR NEXT		BUNAVAIL BUCCAL FILM 2.1-0.3	
MONITOR.....	193	MG.....	226
BEBULIN.....	194	BUNAVAIL BUCCAL FILM 4.2-0.7	
BECONASE AQ.....	195	MG, 6.3-1 MG.....	227
BELBUCA.....	196	BUPHENYL ORAL POWDER 3	
BELSOMRA.....	198	GM/TSP.....	228
BENICAR.....	199	<i>buprenorphine</i>	229
BENICAR HCT.....	200	<i>buprenorphine hcl sublingual</i>	231
BENLYSTA INTRAVENOUS.....	201	<i>buprenorphine hcl-naloxone hcl</i>	232
BENLYSTA SUBCUTANEOUS.....	202	<i>bupropion hcl er (smoking det)</i>	234
BERINERT.....	203	<i>bupropion hcl er (sr)</i>	235
<i>betamethasone dipropionate aug external</i>		<i>bupropion hcl er (xl)</i>	236
<i>gel</i>	204	<i>bupropion hcl oral</i>	233
<i>betamethasone dipropionate aug external</i>		<i>butalbital-apap-caff-cod</i>	237
<i>lotion</i>	205	<i>butalbital-asa-caff-codeine</i>	239
<i>betamethasone dipropionate aug external</i>		<i>butorphanol tartrate nasal</i>	241
<i>ointment</i>	204	BUTRANS.....	243
BETASERON SUBCUTANEOUS KIT		BYDUREON SUBCUTANEOUS	
.....	206	PEN-INJECTOR.....	245
BETHKIS.....	207	BYETTA 10 MCG PEN	
BEVESPI AEROSPHERE.....	208	SUBCUTANEOUS SOLUTION PEN-	
BEVYXXA.....	209	INJECTOR.....	246
<i>bexarotene</i>	210	BYETTA 5 MCG PEN	
<i>bicalutamide</i>	211	SUBCUTANEOUS SOLUTION PEN-	
<i>bimatoprost ophthalmic</i>	212	INJECTOR.....	247
BIVIGAM.....	213	BYSTOLIC ORAL TABLET 10 MG, 5	
BONIVA ORAL TABLET 150 MG....	214	MG.....	248
BOSULIF.....	215	BYSTOLIC ORAL TABLET 2.5 MG..	248
BOTOX.....	216	BYSTOLIC ORAL TABLET 20 MG...	249
BOTOX COSMETIC		BYVALSON.....	250
INTRAMUSCULAR SOLUTION		CABOMETYX.....	251
RECONSTITUTED 50 UNIT.....	217	<i>calcipotriene external cream</i>	252
BREO ELLIPTA.....	218	<i>calcipotriene external ointment</i>	252
BREO ELLIPTA.....	219	<i>calcitonin (salmon)</i>	253
BRILINTA.....	220	<i>calcitrene</i>	254
BRISDELLE.....	221	CANASA.....	255
BRIVIACT ORAL SOLUTION.....	222	<i>candesartan cilexetil oral tablet 16 mg, 4</i>	
BRIVIACT ORAL TABLET.....	223	<i>mg, 8 mg</i>	256

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>candesartan cilexetil-hctz</i>	257	CHANTIX.....	281
<i>capecitabine</i>	258	CHANTIX CONTINUING MONTH	
CAPRELSA ORAL TABLET 100 MG	259	PAK.....	282
CAPRELSA ORAL TABLET 300 MG	260	CHANTIX STARTING MONTH PAK	
CARBAGLU.....	261	.....	283
CARDIZEM LA ORAL TABLET		CHENODAL.....	284
EXTENDED RELEASE 24 HOUR	120	CHOLBAM.....	286
MG.....	262	<i>chorionic gonadotropin intramuscular</i>	287
CARDIZEM LA ORAL TABLET		CIALIS ORAL TABLET 2.5 MG.....	288
EXTENDED RELEASE 24 HOUR	180	CIALIS ORAL TABLET 5 MG.....	288
MG, 300 MG.....	263	CICLODAN EXTERNAL SOLUTION	
CARDIZEM LA ORAL TABLET		.....	289
EXTENDED RELEASE 24 HOUR	240	<i>ciclopirox external solution</i>	290
MG.....	264	CIMZIA PREFILLED.....	292
CARDIZEM LA ORAL TABLET		CIMZIA STARTER KIT.....	293
EXTENDED RELEASE 24 HOUR	360	CIMZIA SUBCUTANEOUS KIT 2 X	
MG.....	265	200 MG.....	291
CARDURA XL.....	266	CINQAIR.....	294
CARIMUNE NF INTRAVENOUS		CINRYZE.....	295
SOLUTION RECONSTITUTED 12		<i>citalopram hydrobromide oral tablet 10</i>	
GM, 6 GM.....	267	<i>mg, 20 mg</i>	296
<i>cartia xt oral capsule extended release 24</i>		<i>citalopram hydrobromide oral tablet 40</i>	
<i>hour 120 mg, 300 mg</i>	268	<i>mg</i>	297
<i>cartia xt oral capsule extended release 24</i>		<i>claravis</i>	298
<i>hour 180 mg</i>	268	CLARINEX ORAL TABLET.....	299
<i>cartia xt oral capsule extended release 24</i>		CLARINEX-D 12 HOUR.....	300
<i>hour 240 mg</i>	269	CLEVER CHEK AUTO-CODE.....	301
CASODEX.....	270	CLEVER CHOICE MICRO SYSTEM	302
CAYSTON.....	271	CLIMARA.....	303
<i>cefixime</i>	272	CLIMARA PRO.....	304
CELEBREX.....	273	<i>clobetasol propionate e</i>	309
<i>celecoxib oral</i>	274	<i>clobetasol propionate emulsion</i>	310
CELEXA ORAL TABLET.....	275	<i>clobetasol propionate external cream</i>	305
CENTANY.....	276	<i>clobetasol propionate external foam</i>	306
CERDELGA.....	277	<i>clobetasol propionate external gel</i>	305
CEREZYME INTRAVENOUS		<i>clobetasol propionate external liquid</i>	307
SOLUTION RECONSTITUTED 400		<i>clobetasol propionate external lotion</i>	308
UNIT.....	278	<i>clobetasol propionate external ointment</i> ..	305
CESAMET.....	279	<i>clobetasol propionate external shampoo</i> ..	308
<i>cevimeline hcl</i>	280	<i>clobetasol propionate external solution</i>	306

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>clodan external shampoo</i>	311	COTELLIC.....	343
<i>clonidine hcl er</i>	312	COTEMPLA XR-ODT.....	344
<i>clopidogrel bisulfate oral</i>	313	COZAAR ORAL TABLET 25 MG.....	345
<i>clozapine oral tablet 100 mg</i>	314	COZAAR ORAL TABLET 50 MG.....	345
<i>clozapine oral tablet 200 mg</i>	315	CRESTOR.....	346
<i>clozapine oral tablet 25 mg, 50 mg</i>	316	CUPRIMINE ORAL CAPSULE 250	
<i>clozapine oral tablet dispersible 100 mg</i> ...	314	MG.....	347
<i>clozapine oral tablet dispersible 12.5 mg</i> ...	317	CUVITRU.....	348
<i>clozapine oral tablet dispersible 150 mg</i> ...	318	<i>cvs nicotine polacrilex mouth/throat</i>	
<i>clozapine oral tablet dispersible 200 mg</i> ...	319	<i>lozenge 4 mg</i>	350
<i>clozapine oral tablet dispersible 25 mg</i>	316	<i>cvs nicotine transdermal patch 24 hour</i>	349
CLOZARIL ORAL TABLET 100 MG.....	320	<i>cvs nts step 1</i>	351
CLOZARIL ORAL TABLET 25 MG.....	321	CYCLOSET.....	352
COAGADEX.....	322	CYMBALTA ORAL CAPSULE	
<i>codeine sulfate oral tablet</i>	323	DELAYED RELEASE PARTICLES	
COLAZAL.....	325	20 MG.....	353
<i>colchicine oral</i>	326	CYMBALTA ORAL CAPSULE	
COMBIPATCH.....	327	DELAYED RELEASE PARTICLES	
COMBIVENT RESPIMAT.....	328	30 MG.....	354
COMETRIQ (100 MG DAILY DOSE).....	329	CYMBALTA ORAL CAPSULE	
COMETRIQ (140 MG DAILY DOSE).....	330	DELAYED RELEASE PARTICLES	
COMETRIQ (60 MG DAILY DOSE).....	331	60 MG.....	355
COMPLERA.....	332	CYSTADANE.....	356
CONCERTA ORAL TABLET		CYSTAGON.....	357
EXTENDED RELEASE 18 MG, 27		CYSTARAN.....	358
MG, 54 MG.....	333	DAKLINZA.....	359
CONCERTA ORAL TABLET		DAKLINZA.....	360
EXTENDED RELEASE 36 MG.....	334	DALIRESP.....	361
COPAXONE SUBCUTANEOUS		<i>dapsone external</i>	362
SOLUTION PREFILLED SYRINGE		<i>darifenacin hydrobromide er</i>	363
40 MG/ML.....	335	DAYTRANA.....	364
CORDRAN EXTERNAL TAPE.....	336	DELZICOL.....	365
COREG CR.....	337	DEMEROL ORAL.....	366
CORIFACT.....	338	DEPEN TITRATABS.....	368
CORLANOR.....	339	DESCOVY.....	369
CORMAX SCALP APPLICATION.....	340	<i>desloratadine</i>	370
COSENTYX.....	341	DESOXYN.....	371
COSENTYX SENSOREADY PEN		<i>desvenlafaxine er</i>	372
SUBCUTANEOUS SOLUTION		<i>desvenlafaxine succinate er</i>	373
AUTO-INJECTOR 150 MG/ML.....	342	DETROL.....	375

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

DETROL LA.....	376	<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg.....</i>	398
DEXEDRINE ORAL CAPSULE		<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg.....</i>	398
EXTENDED RELEASE 24 HOUR.....	377	<i>diltiazem hcl er oral capsule extended release 24 hour 240 mg.....</i>	399
DEXILANT.....	378	<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg.....</i>	405
<i>dexmethylphenidate hcl.....</i>	380	<i>dilt-xr oral capsule extended release 24 hour 240 mg.....</i>	406
<i>dexmethylphenidate hcl er.....</i>	381	DIOVAN.....	407
<i>dextroamphetamine sulfate er.....</i>	384	DIOVAN HCT.....	408
<i>dextroamphetamine sulfate oral solution.....</i>	382	DIPENTUM.....	409
<i>dextroamphetamine sulfate oral tablet.....</i>	383	DITROPAN XL.....	410
<i>diazepam rectal.....</i>	385	DOLOPHINE.....	411
DICLEGIS.....	386	<i>donepezil hcl oral tablet 10 mg.....</i>	413
<i>diclofenac sodium transdermal gel 1 %.....</i>	387	<i>donepezil hcl oral tablet 23 mg, 5 mg.....</i>	414
DIFFERIN EXTERNAL GEL 0.1 %... 388		<i>donepezil hcl oral tablet dispersible.....</i>	414
DIFFERIN EXTERNAL GEL 0.3 %... 388		DOVONEX EXTERNAL CREAM.....	415
DIFFERIN EXTERNAL LOTION..... 388		<i>doxepin hcl external.....</i>	416
DIFICID..... 389		<i>doxercalciferol oral.....</i>	417
<i>dihydroergotamine mesylate nasal.....</i>	390	<i>dronabinol.....</i>	418
DILAUDID ORAL LIQUID..... 391		DUAVEE.....	419
DILAUDID ORAL TABLET..... 393		DUETACT.....	420
<i>diltiazem cd oral capsule extended release 24 hour 120 mg, 180 mg.....</i>	395	DULERA.....	421
<i>diltiazem cd oral capsule extended release 24 hour 240 mg.....</i>	396	<i>duloxetine hcl oral capsule delayed release particles 20 mg, 60 mg.....</i>	422
<i>diltiazem cd oral capsule extended release 24 hour 300 mg.....</i>	397	<i>duloxetine hcl oral capsule delayed release particles 30 mg.....</i>	423
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg.....</i>	400	<i>duloxetine hcl oral capsule delayed release particles 40 mg.....</i>	423
<i>diltiazem hcl er beads oral capsule extended release 24 hour 240 mg.....</i>	401	DUPIXENT.....	424
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg.....</i>	400	DURAGESIC-100.....	425
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg.....</i>	402	DURAGESIC-12.....	427
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg.....</i>	403	DURAGESIC-25.....	429
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg.....</i>	404	DURAGESIC-50.....	431
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg.....</i>	402	DURAGESIC-75.....	433
		DUROLANE.....	435
		<i>dutasteride.....</i>	436
		DUZALLO.....	437

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

DYANAVEL XR.....	438	ENBREL SUBCUTANEOUS	
DYSFORT.....	439	SOLUTION RECONSTITUTED.....	465
<i>econazole nitrate external</i>	440	ENBREL SURECLICK	
EDARBI.....	441	SUBCUTANEOUS SOLUTION	
EDARBYCLOR.....	442	AUTO-INJECTOR.....	467
EDURANT.....	443	<i>endocet oral tablet 10-325 mg, 5-325 mg</i>	468
EFFEXOR XR ORAL CAPSULE		ENDOCET ORAL TABLET 2.5-325	
EXTENDED RELEASE 24 HOUR 150		MG.....	468
MG.....	444	<i>endocet oral tablet 7.5-325 mg</i>	468
EFFEXOR XR ORAL CAPSULE		<i>enoxaparin sodium</i>	470
EXTENDED RELEASE 24 HOUR		ENSTILAR.....	471
37.5 MG.....	445	<i>entecavir</i>	472
EFFEXOR XR ORAL CAPSULE		<i>entecavir</i>	473
EXTENDED RELEASE 24 HOUR 75		ENTRESTO.....	474
MG.....	445	ENTYVIO.....	475
EFFIENT.....	446	EPANED ORAL SOLUTION.....	476
ELAPRASE.....	447	EPCLUSA.....	477
ELELYSO.....	448	<i>epinephrine injection solution auto-</i>	
ELESTRIN.....	449	<i>injector</i>	478
<i>eletriptan hydrobromide</i>	450	EPIPEN 2-PAK INJECTION	
ELIDEL.....	451	SOLUTION AUTO-INJECTOR.....	479
ELIGARD.....	452	EPIPEN JR 2-PAK INJECTION	
ELMIRON.....	453	SOLUTION AUTO-INJECTOR.....	480
ELOCTATE.....	454	EPISNAP.....	481
EMBEDA.....	455	EPOGEN INJECTION SOLUTION	
EMEND ORAL CAPSULE 125 MG,		10000 UNIT/ML, 2000 UNIT/ML,	
80 MG.....	457	20000 UNIT/ML, 3000 UNIT/ML, 4000	
EMEND ORAL CAPSULE 40 MG....	457	UNIT/ML.....	482
EMSAM.....	458	<i>epoprostenol sodium</i>	483
EMTRIVA ORAL CAPSULE.....	459	<i>eprosartan mesylate</i>	484
EMVERM.....	460	<i>eq nicotine transdermal</i>	485
ENABLEX.....	461	ERIVEDGE.....	486
ENABLEX.....	462	ESBRIET ORAL CAPSULE.....	487
ENBREL MINI.....	466	ESBRIET ORAL TABLET 267 MG....	488
ENBREL SUBCUTANEOUS		ESBRIET ORAL TABLET 801 MG....	489
SOLUTION PREFILLED SYRINGE		<i>escitalopram oxalate oral solution</i>	490
25 MG/0.5ML.....	463	<i>escitalopram oxalate oral tablet 10 mg</i>	491
ENBREL SUBCUTANEOUS		<i>escitalopram oxalate oral tablet 20 mg, 5</i>	
SOLUTION PREFILLED SYRINGE		<i>mg</i>	492
50 MG/ML.....	464		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>esomeprazole magnesium oral capsule</i>		FAZACLO ORAL TABLET	
<i>delayed release 40 mg</i>	493	DISPERSIBLE 12.5 MG.....	527
<i>estradiol transdermal patch twice weekly</i>	494	FAZACLO ORAL TABLET	
<i>estradiol transdermal patch weekly</i>	495	DISPERSIBLE 25 MG.....	528
<i>estradiol-norethindrone acet</i>	496	<i>felodipine er</i>	529
ESTROGEL.....	497	FEMRING.....	530
<i>eszopiclone</i>	498	<i>fenofibrate micronized</i>	533
EUFLEXXA INTRA-ARTICULAR		<i>fenofibrate oral capsule</i>	531
SOLUTION PREFILLED SYRINGE.....	499	<i>fenofibrate oral tablet 145 mg, 160 mg, 48</i>	
EVAMIST.....	500	<i>mg, 54 mg</i>	532
EVEKEO.....	501	<i>fenofibric acid oral tablet</i>	534
EVOXAC.....	502	<i>fantanyl</i>	535
EXALGO ORAL TABLET ER 24		<i>fantanyl citrate buccal</i>	537
HOUR ABUSE-DETERRENT 12 MG,		FENTORA BUCCAL TABLET 100	
8 MG.....	503	MCG, 200 MCG, 400 MCG, 600 MCG,	
EXALGO ORAL TABLET ER 24		800 MCG.....	539
HOUR ABUSE-DETERRENT 16 MG	505	FERRIPROX.....	541
EXALGO ORAL TABLET ER 24		FETZIMA.....	542
HOUR ABUSE-DETERRENT 32 MG	507	FETZIMA TITRATION.....	544
EXELON TRANSDERMAL.....	509	FIASP.....	546
EXFORGE.....	510	FIASP FLEXTOUCH.....	547
EXJADE.....	511	FIBRICOR.....	548
EXTAVIA SUBCUTANEOUS KIT.....	512	<i>finasteride oral tablet 5 mg</i>	549
<i>ezetimibe</i>	513	FIORICET/CODEINE ORAL	
<i>ezetimibe-simvastatin</i>	514	CAPSULE 50-300-40-30 MG.....	550
FABIOR.....	515	FIORINAL/CODEINE #3.....	552
FABRAZYME.....	516	FIRAZYR.....	554
FALESSA ORAL KIT 20-1-0.1 MCG-		FIRMAGON.....	555
MG.....	517	FLEBOGAMMA DIF.....	556
<i>famciclovir oral tablet 125 mg, 250 mg</i>	518	FLOLAN.....	557
<i>famciclovir oral tablet 500 mg</i>	519	FLOVENT DISKUS.....	558
FAMVIR ORAL TABLET 500 MG.....	520	FLOVENT HFA.....	559
FANAPT.....	521	<i>fluocinonide external cream 0.05 %</i>	560
FANAPT TITRATION PACK.....	522	<i>fluocinonide external cream 0.1 %</i>	561
FARXIGA.....	523	<i>fluocinonide external gel</i>	561
FARYDAK.....	524	<i>fluocinonide external ointment</i>	561
FASLODEX INTRAMUSCULAR		<i>fluocinonide external solution</i>	561
SOLUTION 250 MG/5ML.....	525	<i>fluoxetine hcl oral capsule delayed release</i>	
FAZACLO ORAL TABLET		.....	562
DISPERSIBLE 100 MG.....	526	<i>fluoxetine hcl oral tablet 20 mg</i>	563

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>fluoxetine hcl oral tablet 60 mg</i>	564	GABITRIL ORAL TABLET 16 MG....	595
<i>fluticasone-salmeterol</i>	565	GABITRIL ORAL TABLET 2 MG.....	596
<i>fluvastatin sodium</i>	566	GABITRIL ORAL TABLET 4 MG.....	594
<i>fluvoxamine maleate er</i>	569	<i>galantamine hydrobromide</i>	597
<i>fluvoxamine maleate oral tablet 100 mg</i> ..	567	<i>galantamine hydrobromide er</i>	598
<i>fluvoxamine maleate oral tablet 25 mg</i>	568	GAMMAGARD.....	599
<i>fluvoxamine maleate oral tablet 50 mg</i>	568	GAMMAGARD S/D LESS IGA.....	600
FOCALIN.....	570	GAMMAKED.....	601
FOCALIN XR.....	571	GAMMAPLEX INTRAVENOUS	
<i>fondaparinux sodium</i>	572	SOLUTION 10 GM/200ML, 20	
FORA D10 2-IN-1 MONITOR.....	573	GM/400ML, 5 GM/100ML.....	602
FORA D15G 2-IN-1 MONITOR.....	574	GAMUNEX-C.....	603
FORA D20 2-IN-1 MONITOR.....	575	GATTEX.....	604
FORTEO SUBCUTANEOUS		<i>gavilyte-c</i>	605
SOLUTION 600 MCG/2.4ML.....	576	<i>gavilyte-g</i>	606
FOSAMAX ORAL TABLET 70 MG... 577		GELNIQUE TRANSDERMAL GEL	
FOSAMAX PLUS D.....	578	10 %.....	607
FRAGMIN SUBCUTANEOUS		GEL-ONE INTRA-ARTICULAR	
SOLUTION 10000 UNIT/ML, 12500		PREFILLED SYRINGE.....	608
UNIT/0.5ML, 15000 UNIT/0.6ML,		GELSYN-3.....	609
18000 UNT/0.72ML, 2500		GENVISC 850.....	610
UNIT/0.2ML, 5000 UNIT/0.2ML, 7500		GENVOYA.....	611
UNIT/0.3ML, 95000 UNIT/3.8ML.....	579	GEODON ORAL.....	612
FREESTYLE FLASH SYSTEM.....	580	GIAZO.....	613
FREESTYLE FREEDOM LITE.....	581	GILENYA.....	614
FREESTYLE INSULINX SYSTEM....	582	GILOTRIF.....	615
FREESTYLE INSULINX TEST.....	583	GLASSIA.....	616
FREESTYLE LITE TEST.....	584	<i>glatopa</i>	617
FREESTYLE PRECISION NEO TEST		GLUCAGEN DIAGNOSTIC.....	618
.....	585	GLUCAGEN HYPOKIT.....	619
FREESTYLE SYSTEM.....	586	GLYXAMBI.....	620
FREESTYLE TEST.....	587	GRALISE ORAL TABLET 300 MG... 621	
FROVA.....	588	GRALISE ORAL TABLET 600 MG... 622	
<i>frovatriptan succinate</i>	589	GRALISE STARTER.....	623
FUZEON SUBCUTANEOUS		GRANIX.....	624
SOLUTION RECONSTITUTED.....	590	<i>guanfacine hcl er</i>	625
FYCOMPA ORAL TABLET.....	591	HAEGARDA.....	626
<i>gabapentin oral capsule</i>	592	<i>halobetasol propionate</i>	627
<i>gabapentin oral tablet</i>	593	HARVONI.....	628
GABITRIL ORAL TABLET 12 MG... 594		<i>heather</i>	629

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

HELIXATE FS.....	630	HUMULIN 70/30.....	648
HEMANGEOL.....	631	HUMULIN N.....	649
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT.....	632	HYALGAN.....	650
HEPSERA.....	633	HYCAMTIN ORAL.....	651
HETLIOZ.....	634	HYCET.....	652
HIZENTRA SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML.....	635	<i>hydrocodone-acetaminophen oral solution</i> <i>2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325</i> <i>mg/15ml.....</i>	654
<i>hm nicotine.....</i>	636	<i>hydrocodone-acetaminophen oral tablet</i> <i>10-300 mg, 10-325 mg, 2.5-325 mg, 5-300</i> <i>mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg....</i>	656
<i>hm nicotine polacrilex mouth/throat</i> <i>lozenge 2 mg.....</i>	637	<i>hydrocodone-ibuprofen oral tablet 10-200</i> <i>mg.....</i>	658
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG.....	638	<i>hydrocodone-ibuprofen oral tablet 5-200</i> <i>mg, 7.5-200 mg.....</i>	658
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG.....	639	<i>hydromorphone hcl er oral tablet er 24</i> <i>hour abuse-deterrent 12 mg, 32 mg, 8 mg</i>	664
HP ACTHAR.....	640	<i>hydromorphone hcl er oral tablet er 24</i> <i>hour abuse-deterrent 16 mg.....</i>	666
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000- 2400 UNIT, 500-1200 UNIT.....	641	<i>hydromorphone hcl oral liquid.....</i>	660
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML.....	644	<i>hydromorphone hcl oral tablet.....</i>	662
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT.....	645	<i>hydromorphone hcl rectal.....</i>	660
HUMIRA PEN-CROHNS STARTER SUBCUTANEOUS PEN-INJECTOR KIT.....	646	HYMOVIS.....	668
HUMIRA PEN-PSORIASIS STARTER SUBCUTANEOUS PEN- INJECTOR KIT.....	647	HYQVIA.....	669
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML.....	642	HYSINGLA ER.....	670
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML.....	643	<i>ibandronate sodium intravenous solution 3</i> <i>mg/3ml.....</i>	672
		<i>ibandronate sodium oral.....</i>	673
		IBRANCE.....	674
		IBUDONE ORAL TABLET 10-200 MG.....	675
		<i>ibudone oral tablet 5-200 mg.....</i>	675
		ICLUSIG ORAL TABLET 15 MG.....	677
		ICLUSIG ORAL TABLET 45 MG.....	678
		IDELVION.....	679
		IDHIFA.....	680
		ILARIS.....	681
		ILARIS (150MG DELIVERED).....	682
		<i>imatinib mesylate oral tablet 100 mg.....</i>	683
		<i>imatinib mesylate oral tablet 400 mg.....</i>	684

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

IMBRUVICA.....	685	INVOKAMET.....	709
<i>imiquimod external</i>	686	INVOKAMET XR.....	710
IMITREX NASAL SOLUTION 20		INVOKANA.....	711
MG/ACT.....	687	<i>ipratropium bromide nasal</i>	712
IMITREX NASAL SOLUTION 5		IPRIVASK.....	713
MG/ACT.....	688	<i>irbesartan</i>	714
IMITREX ORAL.....	689	<i>irbesartan-hydrochlorothiazide</i>	715
IMITREX STATDOSE SYSTEM		IRESSA.....	716
SUBCUTANEOUS SOLUTION		ISENTRESS HD.....	719
AUTO-INJECTOR 6 MG/0.5ML.....	691	ISENTRESS ORAL TABLET.....	717
IMITREX SUBCUTANEOUS.....	690	ISENTRESS ORAL TABLET	
IMPAVIDO.....	692	CHEWABLE.....	718
INCRELEX.....	693	<i>itraconazole oral</i>	720
INDERAL XL ORAL CAPSULE		IXINITY.....	721
EXTENDED RELEASE 24 HOUR 80		JADENU.....	722
MG.....	694	JADENU SPRINKLE.....	723
<i>indomethacin oral</i>	695	JAKAFI.....	724
INFLECTRA.....	696	JANUMET.....	725
INGREZZA ORAL CAPSULE 40 MG	697	JANUMET XR ORAL TABLET	
INGREZZA ORAL CAPSULE 80 MG	698	EXTENDED RELEASE 24 HOUR	
INLYTA.....	699	100-1000 MG, 50-500 MG.....	726
INNOPRAN XL ORAL CAPSULE		JANUMET XR ORAL TABLET	
EXTENDED RELEASE 24 HOUR 120		EXTENDED RELEASE 24 HOUR 50-	
MG.....	700	1000 MG.....	727
INNOPRAN XL ORAL CAPSULE		JANUVIA.....	728
EXTENDED RELEASE 24 HOUR 80		JARDIANCE.....	729
MG.....	701	JENTADUETO.....	730
INTELENCE ORAL TABLET 100		JENTADUETO XR ORAL TABLET	
MG, 25 MG.....	702	EXTENDED RELEASE 24 HOUR 2.5-	
INTELENCE ORAL TABLET 200 MG		1000 MG.....	731
.....	703	JENTADUETO XR ORAL TABLET	
INTRAROSA.....	704	EXTENDED RELEASE 24 HOUR 5-	
INTRON A.....	705	1000 MG.....	732
INTUNIV.....	706	JETREA INTRAVITREAL	
INVEGA ORAL TABLET		SOLUTION 0.375 MG/0.3ML.....	733
EXTENDED RELEASE 24 HOUR 1.5		JEVTANA.....	734
MG, 3 MG, 9 MG.....	707	<i>jinteli</i>	735
INVEGA ORAL TABLET		<i>jolivette</i>	736
EXTENDED RELEASE 24 HOUR 6		JUBLIA.....	737
MG.....	708	JUXTAPID.....	739

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG.....	740	KOATE-DVI.....	772
KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 30 MG, 50 MG, 60 MG, 80 MG.....	742	KOGENATE FS.....	773
KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG, 40 MG.....	744	KOGENATE FS BIO-SET.....	774
KALBITOR.....	746	KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5- 1000 MG.....	775
KALYDECO.....	747	KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5- 1000 MG, 5-500 MG.....	776
KALYDECO.....	748	KORLYM.....	777
KANUMA.....	749	KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT.....	778
KAPVAY ORAL TABLET EXTENDED RELEASE 12 HOUR.....	750	KROGER BLOOD GLUCOSE KIT W/DEVICE.....	779
KAZANO.....	751	KROGER PREMIUM BLOOD GLUCOSE.....	780
KEPIVANCE.....	752	KRYSTEXXA.....	781
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG.....	753	KUVAN.....	782
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 750 MG.....	754	KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE.....	783
KERYDIN.....	755	LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG.....	784
<i>ketoconazole oral</i>	757	LAMICTAL ODT ORAL TABLET DISPERSIBLE 25 MG.....	785
<i>ketorolac tromethamine ophthalmic</i>	758	LAMICTAL ODT ORAL TABLET DISPERSIBLE 50 MG.....	786
<i>ketorolac tromethamine oral</i>	759	LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 25 MG, 50 MG.....	787
KEVEYIS.....	760	LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 200 MG.....	788
KEVZARA.....	761	LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 300 MG.....	789
KHEDEZLA.....	762	<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg</i>	793
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE.....	764		
KISQALI 200 DOSE.....	765		
KISQALI 400 DOSE.....	766		
KISQALI 600 DOSE.....	767		
KISQALI FEMARA 200 DOSE.....	768		
KISQALI FEMARA 400 DOSE.....	769		
KISQALI FEMARA 600 DOSE.....	770		
KOATE.....	771		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

<i>lamotrigine er oral tablet extended release</i>	<i>levorphanol tartrate oral</i>	822
24 hour 200 mg.....	LEVULAN KERASTICK.....	824
794	LEXAPRO ORAL TABLET 10 MG....	825
<i>lamotrigine er oral tablet extended release</i>	LEXAPRO ORAL TABLET 20 MG....	826
24 hour 250 mg, 300 mg.....	LEXAPRO ORAL TABLET 5 MG.....	826
795	LIALDA.....	827
<i>lamotrigine er oral tablet extended release</i>	<i>lidocaine external ointment</i>	828
24 hour 50 mg.....	<i>lidocaine external patch 5 %</i>	830
796	<i>lidocaine pak</i>	831
<i>lamotrigine oral tablet dispersible 100 mg,</i>	<i>lidocaine-prilocaine external cream</i>	832
<i>200 mg</i>	<i>lidocaine-tetracaine</i>	834
790	LIDODERM.....	835
<i>lamotrigine oral tablet dispersible 25 mg.</i>	<i>linezolid oral suspension reconstituted</i>	836
791	<i>linezolid oral tablet</i>	837
<i>lamotrigine oral tablet dispersible 50 mg.</i>	LINZESS ORAL CAPSULE 145 MCG	838
792	LINZESS ORAL CAPSULE 290 MCG	838
LANTUS.....	LINZESS ORAL CAPSULE 72 MCG.	839
797	LIPITOR.....	840
LANTUS SOLOSTAR	LIPOFEN.....	841
SUBCUTANEOUS SOLUTION PEN-	LIVALO.....	842
INJECTOR.....	LOFIBRA ORAL CAPSULE 134 MG,	
798	67 MG.....	843
LARIN FE 1.5/30.....	LOFIBRA ORAL TABLET 54 MG....	844
799	LONSURF ORAL TABLET 15-6.14	
LATUDA ORAL TABLET 120 MG, 20	MG.....	845
MG, 40 MG.....	LONSURF ORAL TABLET 20-8.19	
800	MG.....	846
LATUDA ORAL TABLET 60 MG.....	LORCET.....	847
801	LORCET HD.....	849
LATUDA ORAL TABLET 80 MG.....	LORCET PLUS ORAL TABLET 7.5-	
802	325 MG.....	851
LAZANDA NASAL SOLUTION 100	<i>losartan potassium oral tablet 25 mg, 50</i>	
MCG/ACT, 400 MCG/ACT.....	<i>mg</i>	853
803	LOTRONEX.....	854
LAZANDA NASAL SOLUTION 300	<i>lovastatin</i>	855
MCG/ACT.....	LOVAZA.....	856
805	LOVENOX.....	857
<i>leflunomide oral</i>	LUCENTIS INTRAVITREAL	
807	SOLUTION PREFILLED SYRINGE.	858
LEMTRADA.....		
808		
LENVIMA 10 MG DAILY DOSE.....		
809		
LENVIMA 14 MG DAILY DOSE.....		
810		
LENVIMA 18 MG DAILY DOSE.....		
811		
LENVIMA 20 MG DAILY DOSE.....		
812		
LENVIMA 24 MG DAILY DOSE.....		
813		
LENVIMA 8 MG DAILY DOSE.....		
814		
LESCOL ORAL CAPSULE 20 MG....		
815		
LESCOL XL.....		
816		
LETAIRIS.....		
817		
LEUKINE INTRAVENOUS.....		
818		
<i>leuprolide acetate injection</i>		
819		
<i>levetiracetam er oral tablet extended</i>		
<i>release 24 hour 500 mg</i>		
820		
<i>levetiracetam er oral tablet extended</i>		
<i>release 24 hour 750 mg</i>		
821		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

LUMIGAN OPHTHALMIC SOLUTION 0.01 %.....	859	METADATE ER ORAL TABLET EXTENDED RELEASE 20 MG.....	895
LUMIZYME.....	860	<i>metaxalone oral tablet 400 mg</i>	896
LUNESTA.....	861	<i>methadone hcl intensol</i>	909
LUPANETA PACK.....	862	<i>methadone hcl oral concentrate</i>	897
LUPRON DEPOT (1-MONTH).....	863	<i>methadone hcl oral solution 10 mg/5ml</i>	900
LUPRON DEPOT (3-MONTH).....	864	<i>methadone hcl oral solution 5 mg/5ml</i>	903
LUPRON DEPOT (4-MONTH).....	865	<i>methadone hcl oral tablet</i>	906
LUPRON DEPOT (6-MONTH).....	866	<i>methamphetamine hcl</i>	912
LUPRON DEPOT-PED (1-MONTH)..	867	METHERGINE ORAL.....	913
LUPRON DEPOT-PED (3-MONTH)..	868	METHYLIN ORAL SOLUTION 10 MG/5ML.....	914
LYNPARZA ORAL CAPSULE.....	869	METHYLIN ORAL SOLUTION 5 MG/5ML.....	915
LYNPARZA ORAL TABLET.....	870	<i>methylphenidate hcl er (cd)</i>	925
LYSTEDA.....	871	<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg</i>	926
LYZA.....	872	<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg</i>	927
MACUGEN.....	873	<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg</i>	926
MAKENA.....	874	<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg</i>	928
<i>maprotiline hcl</i>	875	<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	919
MARINOL.....	876	<i>methylphenidate hcl er oral tablet extended release 18 mg, 27 mg, 54 mg</i>	920
<i>matzim la oral tablet extended release 24 hour 180 mg, 300 mg, 360 mg</i>	877	<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	921
<i>matzim la oral tablet extended release 24 hour 240 mg</i>	878	<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg</i>	923
MAVYRET.....	879	<i>methylphenidate hcl er oral tablet extended release 24 hour 36 mg</i>	924
MAXALT.....	880	<i>methylphenidate hcl er oral tablet extended release 36 mg</i>	922
MAXALT-MLT.....	881	<i>methylphenidate hcl oral solution 10 mg/5ml</i>	916
MEIJER BLOOD GLUCOSE.....	882	<i>methylphenidate hcl oral solution 5 mg/5ml</i>	917
MEIJER PREMIUM BLOOD GLUCOSE.....	883		
MEKINIST ORAL TABLET 0.5 MG..	884		
MEKINIST ORAL TABLET 2 MG....	885		
<i>memantine hcl oral tablet 10 mg, 5 mg</i>	886		
MENOSTAR.....	887		
<i>meperidine hcl oral solution</i>	888		
<i>meperidine hcl oral tablet</i>	890		
MEPHYTON.....	892		
<i>mesalamine oral tablet delayed release 1.2 gm</i>	893		
<i>mesalamine oral tablet delayed release 800 mg</i>	894		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>methylphenidate hcl oral tablet</i>	918	<i>morphine sulfate rectal</i>	953
<i>metoprolol succinate er oral tablet</i>		MOZOBIL.....	967
<i>extended release 24 hour 100 mg, 50 mg</i> ..	929	MULTAQ.....	968
<i>metoprolol succinate er oral tablet</i>		<i>mupirocin calcium</i>	970
<i>extended release 24 hour 200 mg</i>	930	<i>mupirocin external</i>	969
<i>metoprolol succinate er oral tablet</i>		MYALEPT.....	971
<i>extended release 24 hour 25 mg</i>	931	MYDAYIS.....	972
MEVACOR ORAL TABLET 40 MG...932		MYOBLOC INTRAMUSCULAR	
MIACALCIN INJECTION.....	933	SOLUTION 2500 UNIT/0.5ML, 5000	
MIACALCIN NASAL.....	934	UNIT/ML.....	973
MICARDIS.....	935	<i>myorisan oral capsule 10 mg, 20 mg, 40</i>	
MICARDIS HCT.....	936	<i>mg</i>	974
<i>mimvey</i>	937	MYORISAN ORAL CAPSULE 30 MG	
MIRAPEX ER.....	938	.....	974
MIRCERA INJECTION SOLUTION		MYRBETRIQ.....	975
PREFILLED SYRINGE.....	939	MYTESI.....	976
<i>mirtazapine oral</i>	940	<i>myzilra</i>	977
MITIGARE.....	941	NAGLAZYME.....	978
<i>modafinil oral tablet 100 mg</i>	942	NAMENDA ORAL TABLET.....	979
<i>modafinil oral tablet 200 mg</i>	944	NAMENDA TITRATION PAK.....	980
MONOCLATE-P INTRAVENOUS		NAMENDA XR.....	981
KIT 1000 UNIT, 1500 UNIT.....	946	NAMZARIC ORAL CAPSULE ER 24	
MONONINE INTRAVENOUS		HOUR THERAPY PACK.....	982
SOLUTION RECONSTITUTED 1000		NAMZARIC ORAL CAPSULE	
UNIT.....	947	EXTENDED RELEASE 24 HOUR 14-	
MONOVISC.....	948	10 MG, 28-10 MG.....	983
<i>montelukast sodium oral</i>	949	<i>naratriptan hcl</i>	984
<i>montelukast sodium oral</i>	950	NASONEX.....	985
MORPHABOND ER.....	951	NATPARA.....	986
<i>morphine sulfate (concentrate) oral</i>		NERLYNX.....	987
<i>solution 100 mg/5ml, 20 mg/ml</i>	957	NESINA.....	988
<i>morphine sulfate er beads</i>	965	NEULASTA SUBCUTANEOUS	
<i>morphine sulfate er oral capsule extended</i>		SOLUTION PREFILLED SYRINGE.....	989
<i>release 24 hour</i>	959	NEUPOGEN INJECTION	
<i>morphine sulfate er oral tablet extended</i>		SOLUTION 300 MCG/ML, 480	
<i>release 100 mg, 30 mg, 60 mg</i>	961	MCG/1.6ML.....	990
<i>morphine sulfate er oral tablet extended</i>		NEUPOGEN INJECTION	
<i>release 15 mg, 200 mg</i>	963	SOLUTION PREFILLED SYRINGE.....	990
<i>morphine sulfate oral solution</i>	953	NEUPRO.....	991
<i>morphine sulfate oral tablet</i>	955	NEURONTIN ORAL CAPSULE.....	992

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NEURONTIN ORAL TABLET.....	993	<i>nisoldipine er oral tablet extended release</i>	
NEUTEK 2TEK		<i>24 hour 17 mg, 20 mg, 25.5 mg, 34 mg, 40</i>	
GLUCOSE/PRESSURE.....	994	<i>mg, 8.5 mg.....</i>	1020
<i>nevirapine er oral tablet extended release</i>		<i>nisoldipine er oral tablet extended release</i>	
<i>24 hour 100 mg.....</i>	995	<i>24 hour 30 mg.....</i>	1021
<i>nevirapine er oral tablet extended release</i>		<i>nitroglycerin translingual solution.....</i>	1022
<i>24 hour 400 mg.....</i>	996	NITROSTAT.....	1023
NEXAVAR.....	997	NITYR.....	1024
NEXIUM 24HR.....	1000	<i>nora-be.....</i>	1025
NEXIUM ORAL CAPSULE		NORCO.....	1026
DELAYED RELEASE 40 MG.....	998	NORDITROPIN FLEXPRO.....	1028
NEXIUM ORAL PACKET.....	999	NORLYROC.....	1029
NEXPLANON.....	1001	NORTHERA ORAL CAPSULE 100	
<i>next choice one dose.....</i>	1002	MG.....	1030
NICODERM CQ.....	1003	NORTHERA ORAL CAPSULE 200	
<i>nicorelief mouth/throat gum.....</i>	1004	MG, 300 MG.....	1031
NICORETTE MOUTH/THROAT		NOVOEIGHT INTRAVENOUS	
GUM.....	1005	SOLUTION RECONSTITUTED 1000	
<i>nicotine step 1.....</i>	1007	UNIT, 2000 UNIT, 250 UNIT, 500	
<i>nicotine step 2.....</i>	1008	UNIT.....	1032
<i>nicotine step 3.....</i>	1009	NOVOLIN 70/30.....	1033
<i>nicotine transdermal patch 24 hour.....</i>	1006	NOVOLIN 70/30 RELION.....	1034
NICOTROL.....	1010	NOVOLIN N.....	1035
NICOTROL NS.....	1011	NOVOLIN N RELION.....	1036
<i>nifediac cc oral tablet extended release 24</i>		NOVOLIN R.....	1037
<i>hour 30 mg.....</i>	1012	NOVOLIN R RELION.....	1038
<i>nifedical xl oral tablet extended release 24</i>		NOVOLOG.....	1039
<i>hour 60 mg.....</i>	1013	NOVOLOG FLEXPEN	
<i>nifedipine er oral tablet extended release</i>		SUBCUTANEOUS SOLUTION PEN-	
<i>24 hour 30 mg, 90 mg.....</i>	1014	INJECTOR.....	1040
<i>nifedipine er oral tablet extended release</i>		NOVOLOG MIX 70/30.....	1041
<i>24 hour 60 mg.....</i>	1015	NOVOLOG MIX 70/30 FLEXPEN	
<i>nifedipine er osmotic release oral tablet</i>		SUBCUTANEOUS SUSPENSION	
<i>extended release 24 hour 30 mg, 90 mg..</i>	1016	PEN-INJECTOR.....	1042
<i>nifedipine er osmotic release oral tablet</i>		NOVOLOG PENFILL	
<i>extended release 24 hour 60 mg.....</i>	1017	SUBCUTANEOUS SOLUTION	
NIKKI.....	1018	CARTRIDGE.....	1043
NINLARO.....	1019	NOVOSEVEN RT.....	1044
		NOXAFIL ORAL TABLET	
		DELAYED RELEASE.....	1045

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

NUCALA.....	1046	ONFI ORAL TABLET 10 MG, 20 MG	1082
NUCYNTA.....	1047	.....	1083
NUCYNTA ER.....	1049	ONGLYZA.....	1084
NUEDEXTA.....	1051	ONZETRA XSAIL.....	1087
NUPLAZID.....	1052	OPANA ER ORAL TABLET ER 12	1089
NUTROPIN AQ NUSPIN 10.....	1053	HOUR ABUSE-DETERRENT.....	1085
NUTROPIN AQ NUSPIN 20.....	1054	OPANA ER ORAL TABLET ER 12	1091
NUTROPIN AQ NUSPIN 5.....	1055	HOUR ABUSE-DETERRENT.....	1092
NUVARING.....	1056	OPANA ORAL.....	1096
NUVIGIL.....	1057	OPSUMIT.....	1093
NUWIQ.....	1059	ORAVIG.....	1096
NYMALIZE ORAL SOLUTION 60		ORENCIA CLICKJECT.....	1093
MG/20ML.....	1060	ORENCIA INTRAVENOUS.....	1094
OCALIVA ORAL TABLET 5 MG.....	1061	ORENCIA SUBCUTANEOUS	
OCTAGAM.....	1062	SOLUTION PREFILLED SYRINGE	
<i>octreotide acetate injection solution 100</i>		125 MG/ML.....	1094
<i>mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50</i>		ORENCIA SUBCUTANEOUS	
<i>mcg/ml, 500 mcg/ml.....</i>	1063	SOLUTION PREFILLED SYRINGE	
ODEFSEY.....	1064	50 MG/0.4ML, 87.5 MG/0.7ML.....	1095
ODOMZO.....	1065	ORENITRAM.....	1097
OFEV.....	1066	ORFADIN.....	1098
<i>olanzapine oral tablet 10 mg, 15 mg, 20</i>		ORKAMBI.....	1099
<i>mg, 5 mg, 7.5 mg.....</i>	1067	ORKAMBI.....	1100
<i>olanzapine oral tablet 2.5 mg.....</i>	1068	ORTHOVISC INTRA-ARTICULAR	
<i>olanzapine oral tablet dispersible.....</i>	1067	SOLUTION PREFILLED SYRINGE	1101
<i>olanzapine-fluoxetine hcl.....</i>	1069	<i>oseltamivir phosphate oral capsule.....</i>	1102
<i>olmesartan medoxomil oral.....</i>	1070	OSENI.....	1103
<i>olmesartan medoxomil-hctz.....</i>	1071	OSPHENA.....	1104
<i>olmesartan-amlodipine-hctz.....</i>	1072	OTEZLA ORAL TABLET.....	1105
OLYSIO.....	1073	OTEZLA ORAL TABLET THERAPY	
<i>omega-3-acid ethyl esters.....</i>	1074	PACK.....	1106
OMNARIS.....	1075	OTREXUP SUBCUTANEOUS	
OMNITROPE.....	1076	SOLUTION AUTO-INJECTOR 10	
ONETOUCH ULTRA 2.....	1077	MG/0.4ML, 12.5 MG/0.4ML, 15	
ONETOUCH ULTRA BLUE.....	1078	MG/0.4ML, 17.5 MG/0.4ML, 20	
ONETOUCH ULTRA MINI.....	1079	MG/0.4ML, 22.5 MG/0.4ML, 25	
ONETOUCH VERIO IN VITRO		MG/0.4ML.....	1107
STRIP.....	1080	OXAYDO.....	1108
ONETOUCH VERIO IQ SYSTEM....	1081		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG.....	1110	<i>paroxetine hcl er oral tablet extended release 24 hour 25 mg.....</i>	1146
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 600 MG.....	1111	<i>paroxetine hcl oral tablet 10 mg, 20 mg.</i>	1143
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg..</i>	1113	<i>paroxetine hcl oral tablet 30 mg, 40 mg.</i>	1144
<i>oxybutynin chloride er oral tablet extended release 24 hour 5 mg.....</i>	1114	<i>paroxetine mesylate.....</i>	1147
<i>oxybutynin chloride oral tablet.....</i>	1112	PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5 MG.....	1151
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 mg.....</i>	1121	PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG.....	1152
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 15 mg, 30 mg, 60 mg.....</i>	1123	PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 37.5 MG.....	1153
<i>oxycodone hcl oral capsule.....</i>	1115	PAXIL ORAL SUSPENSION.....	1148
<i>oxycodone hcl oral concentrate 100 mg/5ml.....</i>	1117	PAXIL ORAL TABLET 10 MG, 20 MG.....	1149
<i>oxycodone hcl oral solution.....</i>	1117	PAXIL ORAL TABLET 30 MG, 40 MG.....	1150
<i>oxycodone hcl oral tablet.....</i>	1119	<i>peg 3350/electrolytes.....</i>	1154
<i>oxycodone-acetaminophen oral solution.</i>	1125	<i>peg-3350/electrolytes.....</i>	1155
<i>oxycodone-acetaminophen oral tablet 10- 325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg.....</i>	1127	PEGASYS PROCLICK.....	1157
<i>oxycodone-aspirin oral tablet 4.8355-325 mg.....</i>	1129	PEGASYS SUBCUTANEOUS SOLUTION.....	1156
<i>oxycodone-ibuprofen.....</i>	1131	PEGINTRON.....	1158
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT.....	1133	PENLAC.....	1159
<i>oxymorphone hcl.....</i>	1135	PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG.....	1161
<i>oxymorphone hcl er.....</i>	1137	PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG.....	1162
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg.....</i>	1139	<i>pentazocine-naloxone hcl.....</i>	1163
<i>paliperidone er oral tablet extended release 24 hour 9 mg.....</i>	1140	PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG.....	1165
PANCREAZE.....	1141	PERFOROMIST.....	1167
<i>paricalcitol oral.....</i>	1142	PERTZYE.....	1168
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 37.5 mg.....</i>	1145	<i>phenoxybenzamine hcl oral.....</i>	1169

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update

<i>pioglitazone hcl-glimepiride</i>	1173	PREZISTA ORAL TABLET 150 MG,	
<i>pioglitazone hcl-metformin hcl</i>	1174	600 MG, 75 MG.....	1202
PLAVIX.....	1175	PREZISTA ORAL TABLET 800 MG	1203
PLEGRIDY STARTER PACK		PRILOSEC OTC.....	1204
SUBCUTANEOUS SOLUTION PEN-		PRIMLEV.....	1205
INJECTOR.....	1178	PRISTIQ.....	1207
PLEGRIDY STARTER PACK		PRIVIGEN.....	1209
SUBCUTANEOUS SOLUTION		PROCARDIA XL ORAL TABLET	
PREFILLED SYRINGE.....	1179	EXTENDED RELEASE 24 HOUR 30	
PLEGRIDY SUBCUTANEOUS		MG.....	1210
SOLUTION PEN-INJECTOR.....	1176	PROCARDIA XL ORAL TABLET	
PLEGRIDY SUBCUTANEOUS		EXTENDED RELEASE 24 HOUR 60	
SOLUTION PREFILLED SYRINGE	1177	MG, 90 MG.....	1211
PLEXION CLEANSING CLOTH		PROCENTRA.....	1212
EXTERNAL PAD.....	1180	PROCRIT.....	1213
POMALYST.....	1181	PROCYSBI ORAL CAPSULE	
PRADAXA.....	1182	DELAYED RELEASE 25 MG.....	1214
PRALUENT SUBCUTANEOUS		PROCYSBI ORAL CAPSULE	
SOLUTION PEN-INJECTOR.....	1183	DELAYED RELEASE 75 MG.....	1215
<i>pramipexole dihydrochloride er</i>	1184	PRODIGY AUTOCODE BLOOD	
<i>pramipexole dihydrochloride er</i>	1185	GLUCOSE KIT.....	1216
<i>prasugrel hcl</i>	1186	PROFILNINE.....	1217
PRAVACHOL ORAL TABLET 20		<i>progesterone micronized oral</i>	1218
MG, 40 MG, 80 MG.....	1187	PROLASTIN-C INTRAVENOUS	
<i>pravastatin sodium</i>	1188	SOLUTION RECONSTITUTED 1000	
PRECISION PCX.....	1189	MG.....	1219
PRECISION PCX PLUS TEST.....	1190	PROLIA.....	1220
PRECISION POINT OF CARE TEST		PROMACTA.....	1221
.....	1191	PROMACTA.....	1222
PRECISION QID TEST.....	1192	PROMETRIUM.....	1223
PRECISION SOF-TACT TEST.....	1193	<i>propafenone hcl er</i>	1224
PRECISION XTRA BLOOD		PROTOPIC.....	1225
GLUCOSE.....	1194	PROVENTIL HFA.....	1227
PREFEST.....	1195	PROVIGIL.....	1228
PREMARIN ORAL.....	1196	PROVIGIL.....	1230
PREMPHASE.....	1197	PROZAC ORAL CAPSULE 10 MG..	1232
PREMPRO.....	1198	PROZAC ORAL CAPSULE 20 MG..	1233
PREVACID SOLUTAB.....	1199	PROZAC ORAL CAPSULE 40 MG..	1234
PREZISTA ORAL SUSPENSION.....	1201	PRUDOXIN.....	1235
		PULMICORT FLEXHALER.....	1236

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

PULMOZYME.....	1237	RASUVO SUBCUTANEOUS	
PURIXAN.....	1238	SOLUTION AUTO-INJECTOR 10	
QBRELIS.....	1239	MG/0.2ML, 12.5 MG/0.25ML, 15	
QNASL.....	1240	MG/0.3ML, 17.5 MG/0.35ML, 20	
QNASL CHILDRENS.....	1241	MG/0.4ML, 22.5 MG/0.45ML, 25	
QUDEXY XR ORAL CAPSULE ER		MG/0.5ML, 30 MG/0.6ML, 7.5	
24 HOUR SPRINKLE 100 MG, 25		MG/0.15ML.....	1259
MG, 50 MG.....	1242	RAVICTI.....	1260
QUDEXY XR ORAL CAPSULE ER		RAYALDEE.....	1261
24 HOUR SPRINKLE 150 MG, 200		RAYOS.....	1262
MG.....	1243	RAZADYNE ORAL TABLET 4 MG, 8	
<i>quetiapine fumarate er oral tablet</i>		MG.....	1263
<i>extended release 24 hour 150 mg, 200 mg</i>		REBETOL ORAL SOLUTION.....	1264
.....	1248	REBIF REBIDOSE	
<i>quetiapine fumarate er oral tablet</i>		SUBCUTANEOUS SOLUTION	
<i>extended release 24 hour 300 mg.....</i>	1249	AUTO-INJECTOR.....	1266
<i>quetiapine fumarate er oral tablet</i>		REBIF REBIDOSE TITRATION	
<i>extended release 24 hour 400 mg.....</i>	1250	PACK SUBCUTANEOUS	
<i>quetiapine fumarate er oral tablet</i>		SOLUTION AUTO-INJECTOR.....	1267
<i>extended release 24 hour 50 mg.....</i>	1251	REBIF SUBCUTANEOUS	
<i>quetiapine fumarate oral tablet 100 mg,</i>		SOLUTION PREFILLED SYRINGE.....	1265
<i>50 mg.....</i>	1244	REBIF TITRATION PACK	
<i>quetiapine fumarate oral tablet 200 mg..</i>	1245	SUBCUTANEOUS SOLUTION	
<i>quetiapine fumarate oral tablet 25 mg...</i>	1246	PREFILLED SYRINGE.....	1268
<i>quetiapine fumarate oral tablet 300 mg,</i>		RECOMBINATE.....	1269
<i>400 mg.....</i>	1247	RECTIV.....	1270
QUILLICHEW ER ORAL TABLET		REGRANEX.....	1271
CHEWABLE EXTENDED RELEASE		RELENZA DISKHALER.....	1272
20 MG, 40 MG.....	1252	RELISTOR ORAL.....	1273
QUILLICHEW ER ORAL TABLET		RELISTOR SUBCUTANEOUS	
CHEWABLE EXTENDED RELEASE		SOLUTION 12 MG/0.6ML.....	1274
30 MG.....	1253	RELISTOR SUBCUTANEOUS	
QUILLIVANT XR.....	1254	SOLUTION 8 MG/0.4ML.....	1275
<i>ra nicotine transdermal.....</i>	1255	RELPAK.....	1276
<i>rabeprazole sodium.....</i>	1256	REMERON.....	1277
RANEXA.....	1257	REMERON SOLTAB.....	1278
<i>rasagiline mesylate oral.....</i>	1258	REMICADE.....	1279
		REMODULIN.....	1280
		<i>repaglinide-metformin hcl.....</i>	1281
		REPATHA.....	1282

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

REPATHA PUSHTRONEX SYSTEM	1283	RISPERDAL ORAL SOLUTION.....	1308
.....	1283	RISPERDAL ORAL TABLET 0.25	
REPATHA SURECLICK.....	1284	MG, 0.5 MG, 1 MG, 2 MG, 3 MG.....	1309
REQUIP XL.....	1285	RISPERDAL ORAL TABLET 4 MG	1310
RESCULA.....	1286	RISPERIDONE M-TAB ORAL	
RESTORIL ORAL CAPSULE 22.5		TABLET DISPERSIBLE 0.5 MG, 1	
MG, 7.5 MG.....	1287	MG, 2 MG.....	1317
RETIN-A.....	1288	RISPERIDONE M-TAB ORAL	
RETIN-A MICRO.....	1290	TABLET DISPERSIBLE 3 MG.....	1318
RETIN-A MICRO PUMP.....	1292	RISPERIDONE M-TAB ORAL	
REVATIO INTRAVENOUS.....	1294	TABLET DISPERSIBLE 4 MG.....	1319
REVATIO ORAL SUSPENSION		<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1</i>	
RECONSTITUTED.....	1295	<i>mg, 2 mg.....</i>	1314
REVATIO ORAL TABLET.....	1296	<i>risperidone oral tablet 3 mg.....</i>	1315
REVLIMID.....	1297	<i>risperidone oral tablet 4 mg.....</i>	1316
REXULTI.....	1298	<i>risperidone oral tablet dispersible 0.5 mg</i>	
REYATAZ ORAL CAPSULE 150 MG		.....	1314
.....	1299	<i>risperidone oral tablet dispersible 1 mg, 2</i>	
REYATAZ ORAL CAPSULE 200 MG		<i>mg.....</i>	1314
.....	1300	<i>risperidone oral tablet dispersible 3 mg..</i>	1315
REYATAZ ORAL CAPSULE 300 MG		<i>risperidone oral tablet dispersible 4 mg..</i>	1316
.....	1299	RITALIN.....	1320
RHOFADE.....	1301	RITALIN LA ORAL CAPSULE	
RIASTAP.....	1302	EXTENDED RELEASE 24 HOUR 10	
RILUTEK.....	1303	MG, 30 MG.....	1321
<i>riluzole.....</i>	1304	RITALIN LA ORAL CAPSULE	
<i>risedronate sodium oral tablet 150 mg...</i>	1305	EXTENDED RELEASE 24 HOUR 20	
<i>risedronate sodium oral tablet 30 mg, 5</i>		MG.....	1322
<i>mg.....</i>	1306	RITALIN LA ORAL CAPSULE	
<i>risedronate sodium oral tablet 35 mg.....</i>	1307	EXTENDED RELEASE 24 HOUR 40	
<i>risedronate sodium oral tablet delayed</i>		MG.....	1322
<i>release.....</i>	1307	RITUXAN INTRAVENOUS	
RISPERDAL M-TAB ORAL TABLET		SOLUTION.....	1323
DISPERSIBLE 0.5 MG.....	1311	<i>rivastigmine.....</i>	1324
RISPERDAL M-TAB ORAL TABLET		<i>rivastigmine tartrate.....</i>	1325
DISPERSIBLE 1 MG.....	1311	RIXUBIS.....	1326
RISPERDAL M-TAB ORAL TABLET		<i>rizatriptan benzoate.....</i>	1327
DISPERSIBLE 3 MG.....	1312	<i>ropinirole hcl er oral tablet extended</i>	
RISPERDAL M-TAB ORAL TABLET		<i>release 24 hour 12 mg.....</i>	1328
DISPERSIBLE 4 MG.....	1313		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>ropinirole hcl er oral tablet extended</i>	SEROQUEL ORAL TABLET 300 MG
<i>release 24 hour 2 mg, 4 mg, 6 mg, 8 mg</i> 1329	..... 1361
<i>rosuvastatin calcium</i> 1330	SEROQUEL ORAL TABLET 400 MG
ROXICODONE ORAL TABLET..... 1331	..... 1361
ROZEREM..... 1333	SEROQUEL XR ORAL TABLET
RUBRACA..... 1334	EXTENDED RELEASE 24 HOUR 150
RUCONEST..... 1335	MG, 200 MG..... 1362
RYDAPT..... 1336	SEROQUEL XR ORAL TABLET
RYTHMOL SR..... 1337	EXTENDED RELEASE 24 HOUR 300
SABRIL..... 1338	MG, 400 MG, 50 MG..... 1364
SABRIL..... 1339	SEROSTIM SUBCUTANEOUS
SAIZEN..... 1340	SOLUTION RECONSTITUTED 4
SAIZEN CLICK.EASY..... 1341	MG, 5 MG, 6 MG..... 1366
SAMSCA ORAL TABLET 15 MG..... 1342	<i>sertraline hcl oral tablet 100 mg</i> 1367
SAMSCA ORAL TABLET 30 MG..... 1343	<i>sertraline hcl oral tablet 25 mg</i> 1368
SANCUSO..... 1344	<i>sertraline hcl oral tablet 50 mg</i> 1369
SANDOSTATIN..... 1345	SHAROBEL..... 1370
SANDOSTATIN LAR DEPOT..... 1346	SIGNIFOR..... 1371
SANTYL..... 1347	<i>sildenafil citrate oral</i> 1372
SAPHRIS..... 1348	SILIQ..... 1373
SAVAYSA..... 1349	SIMPONI ARIA..... 1375
SAVELLA..... 1350	SIMPONI SUBCUTANEOUS
SAVELLA TITRATION PACK..... 1351	SOLUTION AUTO-INJECTOR..... 1374
SEEBRI NEOHALER..... 1352	SIMPONI SUBCUTANEOUS
SELZENTRY ORAL SOLUTION..... 1353	SOLUTION PREFILLED SYRINGE..... 1374
SELZENTRY ORAL TABLET 150	<i>simvastatin oral</i> 1376
MG..... 1354	SINGULAIR ORAL TABLET..... 1377
SELZENTRY ORAL TABLET 25 MG	SINGULAIR ORAL TABLET
..... 1355	CHEWABLE..... 1377
SELZENTRY ORAL TABLET 75 MG	SIRTURO..... 1378
..... 1354	SIVEXTRO ORAL..... 1379
SENSIPAR..... 1356	SKYLA..... 1380
SEREVENT DISKUS..... 1357	<i>sm nicotine transdermal</i> 1381
SEROQUEL ORAL TABLET 100 MG,	<i>sodium phenylbutyrate oral powder 3</i>
50 MG..... 1358	<i>gmltsp</i> 1382
SEROQUEL ORAL TABLET 200 MG	<i>sodium phenylbutyrate oral tablet</i> 1382
..... 1359	<i>solia</i> 1383
SEROQUEL ORAL TABLET 25 MG 1360	SOLQUA..... 1384
	SOMATULINE DEPOT..... 1385
	SOMAVERT..... 1386

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SONATA ORAL CAPSULE 10 MG..	1387	<i>sumatriptan succinate refill subcutaneous</i>	
SONATA ORAL CAPSULE 5 MG...	1388	<i>solution cartridge</i>	1420
SOOLANTRA.....	1389	<i>sumatriptan succinate subcutaneous</i>	
SORIATANE ORAL CAPSULE 10		<i>solution 6 mg/0.5ml</i>	1417
MG, 17.5 MG, 25 MG.....	1390	<i>sumatriptan succinate subcutaneous</i>	
SOVALDI.....	1391	<i>solution auto-injector 4 mg/0.5ml</i>	1418
SPIRIVA HANDIHALER.....	1392	<i>sumatriptan succinate subcutaneous</i>	
SPIRIVA RESPIMAT.....	1393	<i>solution auto-injector 6 mg/0.5ml</i>	1419
SPORANOX ORAL CAPSULE.....	1394	SUPARTZ FX.....	1422
SPORANOX PULSEPAK.....	1395	SUPARTZ INTRA-ARTICULAR	
SPRITAM.....	1396	SOLUTION PREFILLED SYRINGE	1421
SPRYCEL ORAL TABLET 100 MG,		SUPPRELIN LA.....	1423
140 MG.....	1397	SUTENT ORAL CAPSULE 12.5 MG	1424
SPRYCEL ORAL TABLET 20 MG, 50		SUTENT ORAL CAPSULE 25 MG...	1425
MG, 70 MG, 80 MG.....	1398	SUTENT ORAL CAPSULE 37.5 MG,	
STELARA INTRAVENOUS.....	1399	50 MG.....	1426
STELARA SUBCUTANEOUS		SYLATRON SUBCUTANEOUS KIT	
SOLUTION PREFILLED SYRINGE	1400	200 MCG, 300 MCG, 600 MCG.....	1427
STIOLTO RESPIMAT.....	1401	SYMBICORT.....	1428
STIVARGA.....	1402	SYMBYAX ORAL CAPSULE 12-25	
STRATTERA ORAL CAPSULE 10		MG, 12-50 MG, 6-25 MG, 6-50 MG...	1429
MG, 18 MG, 25 MG, 40 MG, 60 MG.	1403	SYMLINPEN 120 SUBCUTANEOUS	
STRATTERA ORAL CAPSULE 100		SOLUTION PEN-INJECTOR.....	1430
MG, 80 MG.....	1404	SYMLINPEN 60 SUBCUTANEOUS	
STRENSIQ.....	1405	SOLUTION PEN-INJECTOR.....	1432
STRIBILD.....	1406	SYMPROIC.....	1434
STRIVERDI RESPIMAT.....	1407	SYNAGIS.....	1435
SUBOXONE SUBLINGUAL FILM		SYNALGOS-DC.....	1436
12-3 MG.....	1408	SYNAREL.....	1438
SUBOXONE SUBLINGUAL FILM 2-		SYNDROS.....	1439
0.5 MG, 4-1 MG, 8-2 MG.....	1409	SYNERA.....	1440
SUBSYS.....	1410	SYNJARDY.....	1441
SULAR ORAL TABLET EXTENDED		SYNJARDY XR ORAL TABLET	
RELEASE 24 HOUR 17 MG, 34 MG,		EXTENDED RELEASE 24 HOUR 10-	
8.5 MG.....	1412	1000 MG, 12.5-1000 MG, 5-1000 MG.	1442
<i>sulfasalazine oral</i>	1413	SYNJARDY XR ORAL TABLET	
<i>sulfazine</i>	1414	EXTENDED RELEASE 24 HOUR 25-	
<i>sumatriptan nasal</i>	1415	1000 MG.....	1443
<i>sumatriptan succinate oral</i>	1416	SYNRIBO.....	1444

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE	1445	TESTIM.....	1478
SYNVISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE	1446	<i>testosterone cypionate intramuscular solution 100 mg/ml</i>	1487
SYPRINE.....	1447	<i>testosterone cypionate intramuscular solution 200 mg/ml</i>	1488
TACLONEX EXTERNAL OINTMENT.....	1448	<i>testosterone transdermal gel 10 mg/lact (2%)</i>	1480
TACLONEX EXTERNAL SUSPENSION.....	1449	<i>testosterone transdermal gel 12.5 mg/lact (1%)</i>	1481
<i>tacrolimus external</i>	1450	<i>testosterone transdermal gel 25 mg/2.5gm (1%)</i>	1483
TAFINLAR.....	1452	<i>testosterone transdermal gel 50 mg/5gm (1%)</i>	1481
TAGRISSO.....	1453	<i>testosterone transdermal solution</i>	1485
<i>take action</i>	1454	<i>tetrabenazine oral tablet 12.5 mg</i>	1489
TALTZ.....	1455	<i>tetrabenazine oral tablet 25 mg</i>	1490
TAMIFLU ORAL CAPSULE.....	1456	TGT BLOOD GLUCOSE MONITORING.....	1491
TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML.....	1457	<i>tgt nicotine step one</i>	1492
TANZEUM.....	1458	<i>tgt nicotine step three</i>	1493
TARCEVA.....	1459	<i>tgt nicotine step two</i>	1494
TARGRETIN EXTERNAL.....	1460	THALOMID.....	1495
TASIGNA.....	1461	THIOLA.....	1496
<i>tazarotene external</i>	1462	<i>thrive mouth/throat gum 2 mg</i>	1497
TAZORAC.....	1463	<i>tiagabine hcl oral tablet 2 mg</i>	1498
<i>taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg</i> ...	1464	<i>tiagabine hcl oral tablet 4 mg</i>	1499
<i>taztia xt oral capsule extended release 24 hour 240 mg</i>	1465	TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 300 MG, 360 MG, 420 MG.....	1500
TECFIDERA.....	1466	TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG.....	1501
TECFIDERA.....	1467	TIROSINT.....	1502
TECHNIVIE.....	1468	TIVICAY.....	1503
TEKTURNA.....	1469	TIVICAY.....	1504
TEKTURNA HCT.....	1470	TIVORBEX.....	1505
<i>telmisartan</i>	1471	TOBI.....	1506
<i>telmisartan-amlodipine</i>	1472	TOBI PODHALER.....	1507
<i>telmisartan-hctz</i>	1473	<i>tobramycin inhalation</i>	1508
<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	1474		
TEMODAR ORAL.....	1475		
TEMOVATE EXTERNAL CREAM.....	1476		
<i>temozolomide</i>	1477		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>tolterodine tartrate er</i>	1509	TROKENDI XR.....	1549
TOPAMAX SPRINKLE.....	1510	<i>trospium chloride</i>	1550
TOPROL XL ORAL TABLET		<i>trospium chloride er</i>	1551
EXTENDED RELEASE 24 HOUR 100		TRUERESULT BLOOD GLUCOSE	1552
MG, 50 MG.....	1511	TRUETRACK BLOOD GLUCOSE	
TOPROL XL ORAL TABLET		KIT.....	1553
EXTENDED RELEASE 24 HOUR 200		TRUETRACK SMART SYSTEM.....	1554
MG.....	1512	TRULICITY.....	1555
TOPROL XL ORAL TABLET		TRUVADA.....	1556
EXTENDED RELEASE 24 HOUR 25		TUDORZA PRESSAIR	
MG.....	1513	INHALATION AEROSOL POWDER	
TOUJEO SOLOSTAR.....	1514	BREATH ACTIVATED.....	1557
TOVIAZ.....	1515	TUSSICAPS.....	1558
TRACLEER.....	1516	TWYNSTA.....	1559
TRADJENTA.....	1517	TYBOST.....	1560
<i>tramadol hcl er (biphasic)</i>	1522	TYKERB.....	1561
<i>tramadol hcl er oral tablet extended</i>		TYLENOL WITH CODEINE #3.....	1562
<i>release 24 hour</i>	1520	TYLENOL WITH CODEINE #4.....	1564
<i>tramadol hcl oral</i>	1518	TYMLOS.....	1566
<i>tramadol-acetaminophen</i>	1524	TYSABRI.....	1567
<i>tranexamic acid oral</i>	1526	TYVASO.....	1568
TRELEGY ELLIPTA.....	1527	TYVASO REFILL.....	1569
TRELSTAR MIXJECT.....	1528	TYVASO STARTER.....	1570
TREMFYA.....	1529	UCERIS ORAL.....	1571
<i>tretinoin external cream</i>	1530	UCERIS RECTAL.....	1572
<i>tretinoin external gel 0.01 %, 0.025 %...</i>	1530	ULESFIA.....	1573
<i>tretinoin microsphere</i>	1532	ULORIC.....	1574
<i>tretinoin microsphere pump</i>	1534	ULTRACET.....	1575
TRETIN-X EXTERNAL CREAM		ULTRAM.....	1577
0.075 %.....	1536	ULTRAVATE EXTERNAL LOTION	
TRETTEN.....	1538	.....	1579
TREZIX ORAL CAPSULE 320.5-30-16		UPTRAVI ORAL TABLET 1000	
MG.....	1539	MCG, 1200 MCG, 1400 MCG, 1600	
TRIBENZOR.....	1541	MCG, 400 MCG, 600 MCG, 800 MCG	
TRICOR.....	1542	.....	1580
TRIGLIDE ORAL TABLET 160 MG	1543	UPTRAVI ORAL TABLET 200 MCG	
TRILIPIX.....	1544	.....	1581
TRINTELLIX.....	1545	UPTRAVI ORAL TABLET	
TRIPTODUR.....	1547	THERAPY PACK.....	1581
TRIUMEQ.....	1548	UTIBRON NEOHALER.....	1582

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

VALCHLOR.....	1583	<i>verapamil hcl er oral capsule extended</i>	
VALCYTE ORAL SOLUTION		<i>release 24 hour 200 mg.....</i>	1612
RECONSTITUTED.....	1584	VERDROCET.....	1613
VALCYTE ORAL TABLET.....	1585	VERSACLOZ.....	1615
<i>valganciclovir hcl oral solution</i>		VERZENIO.....	1616
<i>reconstituted.....</i>	1586	VESICARE.....	1617
<i>valganciclovir hcl oral tablet.....</i>	1587	VIBERZI.....	1618
<i>valsartan.....</i>	1588	<i>vicodin es oral tablet 7.5-300 mg.....</i>	1621
<i>valsartan-hydrochlorothiazide.....</i>	1589	<i>vicodin hp oral tablet 10-300 mg.....</i>	1623
VANTAS.....	1590	<i>vicodin oral tablet 5-300 mg.....</i>	1619
VARUBI ORAL.....	1591	VICTOZA SUBCUTANEOUS	
VASCEPA ORAL CAPSULE 0.5 GM.....	1592	SOLUTION PEN-INJECTOR.....	1625
VASCEPA ORAL CAPSULE 1 GM..	1593	VIEKIRA PAK.....	1626
VECAMYL.....	1594	VIEKIRA XR.....	1627
VELETRI.....	1595	<i>vigabatrin.....</i>	1628
VELTASSA.....	1596	VIIBRYD ORAL TABLET.....	1629
VELTIN.....	1597	VIMIZIM.....	1630
VEMLIDY.....	1598	VIMPAT ORAL SOLUTION.....	1631
VENCLEXTA ORAL TABLET 10 MG		VIMPAT ORAL TABLET.....	1632
.....	1599	VIOKACE.....	1633
VENCLEXTA ORAL TABLET 100		<i>viorele.....</i>	1634
MG.....	1600	VIRAMUNE XR ORAL TABLET	
VENCLEXTA ORAL TABLET 50 MG		EXTENDED RELEASE 24 HOUR 100	
.....	1601	MG.....	1635
VENCLEXTA STARTING PACK....	1602	VIRAMUNE XR ORAL TABLET	
<i>venlafaxine hcl er oral capsule extended</i>		EXTENDED RELEASE 24 HOUR 400	
<i>release 24 hour 150 mg.....</i>	1607	MG.....	1636
<i>venlafaxine hcl er oral capsule extended</i>		VIREAD ORAL TABLET.....	1637
<i>release 24 hour 37.5 mg, 75 mg.....</i>	1608	VISTOGARD.....	1638
<i>venlafaxine hcl er oral tablet extended</i>		VIVLODEX.....	1639
<i>release 24 hour 225 mg.....</i>	1609	VOGELXO PUMP.....	1642
<i>venlafaxine hcl oral tablet 100 mg, 25 mg</i>		VOGELXO TRANSDERMAL GEL 50	
.....	1603	MG/5GM (1%).....	1640
<i>venlafaxine hcl oral tablet 37.5 mg.....</i>	1604	VOLTAREN TRANSDERMAL.....	1644
<i>venlafaxine hcl oral tablet 50 mg.....</i>	1605	VONVENDI.....	1645
<i>venlafaxine hcl oral tablet 75 mg.....</i>	1606	VOSEVI.....	1646
VENTAVIS.....	1610	VOTRIENT.....	1647
<i>verapamil hcl er oral capsule extended</i>		VPRIV.....	1648
<i>release 24 hour 100 mg, 300 mg.....</i>	1611		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

VRAYLAR ORAL CAPSULE 1.5 MG	1649	XURIDEN.....	1683
VRAYLAR ORAL CAPSULE 3 MG	1650	XYLON.....	1684
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG.....	1651	XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT.....	1685
VRAYLAR ORAL CAPSULE THERAPY PACK.....	1652	XYNTHA SOLOFUSE INTRAVENOUS KIT 3000 UNIT.....	1686
VYTORIN.....	1653	XYREM.....	1687
VYVANSE.....	1654	YERVOY.....	1688
VYVANSE.....	1655	<i>zafirlukast</i>	1689
WELLBUTRIN SR.....	1656	<i>zaleplon</i>	1690
XADAGO.....	1657	ZALTRAP.....	1691
XALATAN.....	1658	ZARXIO.....	1692
XALKORI.....	1659	ZAVESCA.....	1693
XANAX XR.....	1660	ZEGERID OTC.....	1694
XATMEP.....	1661	ZEJULA.....	1695
XELJANZ.....	1662	ZELBORAF.....	1696
XELJANZ XR.....	1663	ZEMAIRA.....	1697
XELODA.....	1664	ZEMBRACE SYMTOUCH.....	1698
XENAZINE ORAL TABLET 12.5 MG	1665	<i>zenatane oral capsule 10 mg, 20 mg, 40 mg</i>	1699
XENAZINE ORAL TABLET 25 MG	1666	ZENATANE ORAL CAPSULE 30 MG	1700
XEOMIN.....	1667	ZENZEDI ORAL TABLET 10 MG, 5 MG.....	1701
XERMELO.....	1668	ZEPATIER.....	1702
XGEVA.....	1669	ZETIA.....	1703
XIFAXAN ORAL TABLET 200 MG	1670	ZETONNA.....	1704
XIFAXAN ORAL TABLET 550 MG	1671	ZIANA.....	1705
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10- 1000 MG, 10-500 MG, 5-500 MG.....	1672	<i>zileuton er</i>	1706
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5- 1000 MG.....	1673	ZINBRYTA.....	1707
XODOL.....	1674	ZIOPTAN.....	1708
XOLAIR.....	1676	<i>ziprasidone hcl</i>	1709
XOPENEX HFA.....	1677	ZOCOR.....	1710
XTAMPZA ER.....	1678	ZOHYDRO ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT.....	1711
XTANDI.....	1680	ZOLADEX.....	1713
XULANE.....	1681	<i>zoledronic acid intravenous concentrate</i>	1714
XULTOPHY.....	1682	<i>zoledronic acid intravenous solution</i>	1714
		ZOLINZA.....	1715

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open Formulary

Last Update 12/2017

Next Update

<i>zolmitriptan oral tablet 2.5 mg</i>	1716	ZYVOX ORAL TABLET	1747
<i>zolmitriptan oral tablet 5 mg</i>	1717		
<i>zolmitriptan oral tablet dispersible 2.5 mg</i>	1718		
<i>zolmitriptan oral tablet dispersible 5 mg</i>	1719		
ZOLOFT ORAL TABLET 100 MG...	1720		
ZOLOFT ORAL TABLET 25 MG.....	1721		
ZOLOFT ORAL TABLET 50 MG.....	1722		
<i>zolpidem tartrate er</i>	1724		
<i>zolpidem tartrate oral</i>	1723		
ZOMETA INTRAVENOUS CONCENTRATE.....	1725		
ZOMIG NASAL SOLUTION 5 MG..	1726		
ZOMIG ORAL.....	1727		
ZOMIG ZMT.....	1728		
ZONALON.....	1729		
ZONTIVITY.....	1730		
ZORBTIVE.....	1731		
ZORVOLEX.....	1732		
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG.....	1733		
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.....	1734		
ZURAMPIC.....	1735		
ZYBAN.....	1736		
ZYDELIG.....	1737		
ZYFLO.....	1738		
ZYFLO CR.....	1739		
ZYKADIA.....	1740		
ZYPREXA ORAL TABLET 10 MG, 15 MG, 20 MG, 7.5 MG.....	1741		
ZYPREXA ORAL TABLET 2.5 MG.	1742		
ZYPREXA ORAL TABLET 5 MG....	1741		
ZYPREXA ZYDIS.....	1743		
ZYTIGA ORAL TABLET 250 MG....	1744		
ZYTIGA ORAL TABLET 500 MG....	1745		
ZYVOX ORAL SUSPENSION RECONSTITUTED.....	1746		

2017 Aetna Pharmacy Drug Guide - Aetna Funding Advantage Value Plus Five Tier Open
Formulary

Last Update 12/2017

Next Update