# Acamprosate Calcium

**Products Affected**

- *acamprosate calcium*

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

# Accu-Chek Aviva Plus

**Products Affected**

- ACCU-CHEK AVIVA PLUS IN VITRO

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

# Accu-Chek Compact Plus

**Products Affected**

- ACCU-CHEK COMPACT PLUS

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

# Accu-Chek SmartView

**Products Affected**

- ACCU-CHEK SMARTVIEW

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

# Accu-Chek Softclix Lancet Dev

**Products Affected**

- ACCU-CHEK SOFTCLIX LANCET DEV KIT

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

# Accutrend Glucose

**Products Affected**

- ACCUTREND GLUCOSE

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

# Acetaminophen-Codeine

**Products Affected**

- *acetaminophen-codeine oral solution*

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

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

# Acetaminophen-Codeine

**Products Affected**

- *acetaminophen-codeine oral tablet*

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

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

# Acetaminophen-Codeine #2

**Products Affected**

- *acetaminophen-codeine #2*

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

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

# Acetaminophen-Codeine #3

**Products Affected**

- *acetaminophen-codeine #3*

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

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

# Acetaminophen-Codeine #4

**Products Affected**

- *acetaminophen-codeine #4*

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

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

# Acitretin

**Products Affected**

- *acitretin*

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

# Acitretin

**Products Affected**

- *acitretin*

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

# Actemra

**Products Affected**

- ACTEMRA INTRAVENOUS

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

# Actemra

**Products Affected**

- ACTEMRA SUBCUTANEOUS

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

# Actimmune

**Products Affected**

- ACTIMMUNE

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

# Actoplus met XR

**Products Affected**

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

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of metformin 1500mg/day |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Actoplus met XR

**Products Affected**

- ACTOPLUS MET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 30-1000 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of metformin 1500mg/day |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Adapalene

**Products Affected**

- *adapalene external lotion*

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

# Adcirca

**Products Affected**

- ADCIRCA

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

# Addyi

**Products Affected**

- ADDYI

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

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

# Adefovir Dipivoxil

**Products Affected**

- *adefovir dipivoxil*

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

# Adempas

**Products Affected**

- ADEMPAS

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

# Advair Diskus

**Products Affected**

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

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

# Advair Diskus

**Products Affected**

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

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

# Advair HFA

**Products Affected**

- ADVAIR HFA

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

# Advance Intuition Test

**Products Affected**

- ADVANCE INTUITION TEST

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

# Advate

**Products Affected**

- ADVATE

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

# Advocate Duo

**Products Affected**

- ADVOCATE DUO DEVICE

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

# Advocate Redi-Code

**Products Affected**

- ADVOCATE REDI-CODE IN VITRO

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

# Advocate Redi-Code+ Test

**Products Affected**

- ADVOCATE REDI-CODE+ TEST

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

# Advocate Test

**Products Affected**

- ADVOCATE TEST

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

# Afeditab CR

**Products Affected**

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

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

# Afeditab CR

**Products Affected**

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

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

# Afinitor

**Products Affected**

- AFINITOR

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

# AgaMatrix AMP Test

**Products Affected**

- AGAMATRIX AMP TEST

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

# AgaMatrix Jazz Test

**Products Affected**

- AGAMATRIX JAZZ TEST

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

# AgaMatrix KeyNote Test

**Products Affected**

- AGAMATRIX KEYNOTE TEST

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

# AgaMatrix Presto Test

**Products Affected**

- AGAMATRIX PRESTO TEST

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

# Akynzeo

**Products Affected**

- AKYNZEO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Prophylaxis of nausea and vomiting associated with cancer chemotherapy |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of nausea and vomiting associated with cancer chemotherapy |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of aprepitant and either ondansetron or granisetron |
| **QL Criteria** | 2 capsules Per 1 month |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Aldurazyme

**Products Affected**

- ALDURAZYME

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

# Alendronate Sodium

**Products Affected**

- *alendronate sodium oral tablet 10 mg*

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

# Alendronate Sodium

**Products Affected**

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

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

# Alendronate Sodium

**Products Affected**

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

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

# Alfuzosin HCl ER

**Products Affected**

- *alfuzosin hcl er*

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

# Alimta

**Products Affected**

- ALIMTA

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

# Almotriptan Malate

**Products Affected**

- *almotriptan malate*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan |
| **QL Criteria** | 6 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Alogliptin Benzoate

**Products Affected**

- *alogliptin benzoate*

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

# Alogliptin-Metformin HCl

**Products Affected**

- *alogliptin-metformin hcl*

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

# Alogliptin-Pioglitazone

**Products Affected**

- *alogliptin-pioglitazone*

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

# Alosetron HCl

**Products Affected**

- *alosetron hcl*

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

# Aloxi

**Products Affected**

- ALOXI INTRAVENOUS SOLUTION 0.25 MG/5ML

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | PENDING |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | PENDING |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ALPRAZolam ER

**Products Affected**

- *alprazolam er*

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

# ALPRAZolam XR

**Products Affected**

- *alprazolam xr*

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

# Altoprev

**Products Affected**

- ALTOPREV

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following:  atorvastatin, lovastatin, pravastatin, simvastain |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Alvesco

**Products Affected**

- ALVESCO

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

# Amitiza

**Products Affected**

- AMITIZA

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of lactulose or polyethylene glycol |
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Amlodipine Besylate-Valsartan

**Products Affected**

- *amlodipine besylate-valsartan*

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

# Amlodipine-Olmesartan

**Products Affected**

- *amlodipine-olmesartan*

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

# Amlodipine-Valsartan-HCTZ

**Products Affected**

- *amlodipine-valsartan-hctz*

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

# Amnesteem

**Products Affected**

- *amnesteem*

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

# Amphetamine-Dextroamphet ER

**Products Affected**

- *amphetamine-dextroamphet er*

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

# Amphetamine-Dextroamphetamine

**Products Affected**

- *amphetamine-dextroamphetamine*

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

# Ampyra

**Products Affected**

- AMPYRA

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

# Anoro Ellipta

**Products Affected**

- ANORO ELLIPTA

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

# Anzemet

**Products Affected**

- ANZEMET ORAL

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

# APAP-Caff-Dihydrocodeine

**Products Affected**

- *apap-caff-dihydrocodeine oral capsule*

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

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

# Apidra

**Products Affected**

- APIDRA

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

# Apidra SoloStar

**Products Affected**

- APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# Aprepitant

**Products Affected**

- *aprepitant oral capsule 40 mg, 80 mg*

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

# Aprepitant

**Products Affected**

- *aprepitant oral capsule 80 & 125 mg*

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

# Apriso

**Products Affected**

- APRISO

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

# Aptiom

**Products Affected**

- APTIOM ORAL TABLET 200 MG

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

# Aralast NP

**Products Affected**

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG

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

# Aranesp (Albumin Free)

**Products Affected**

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

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

# Arcalyst

**Products Affected**

- ARCALYST

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

# Arcapta Neohaler

**Products Affected**

- ARCAPTA NEOHALER

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

# ARIPiprazole

**Products Affected**

- *aripiprazole oral solution*

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

# ARIPiprazole

**Products Affected**

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

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

# Armodafinil

**Products Affected**

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

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

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

# Armodafinil

**Products Affected**

- *armodafinil oral tablet 50 mg*

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

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

# Arzerra

**Products Affected**

- ARZERRA

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

# Ascomp-Codeine

**Products Affected**

- *ascomp-codeine*

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

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

# Asmanex 120 Metered Doses

**Products Affected**

- ASMANEX 120 METERED DOSES

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

# Asmanex 14 Metered Doses

**Products Affected**

- ASMANEX 14 METERED DOSES

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

# Asmanex 30 Metered Doses

**Products Affected**

- ASMANEX 30 METERED DOSES

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

# Asmanex 60 Metered Doses

**Products Affected**

- ASMANEX 60 METERED DOSES

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

# Asmanex HFA

**Products Affected**

- ASMANEX HFA

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

# Assure 3 Test

**Products Affected**

- ASSURE 3 TEST

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

# Assure 4 Test

**Products Affected**

- ASSURE 4 TEST

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

# Assure Platinum

**Products Affected**

- ASSURE PLATINUM

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

# Assure Pro Test

**Products Affected**

- ASSURE PRO TEST

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

# Atomoxetine HCl

**Products Affected**

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

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

# Atomoxetine HCl

**Products Affected**

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

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

# Atorvastatin Calcium

**Products Affected**

- *atorvastatin calcium oral*

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

# Atripla

**Products Affected**

- ATRIPLA

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

# Aubagio

**Products Affected**

- AUBAGIO

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

# Avandia

**Products Affected**

- AVANDIA ORAL TABLET 2 MG, 4 MG

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

# Avonex

**Products Affected**

- AVONEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 1 kit Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Avonex Pen

**Products Affected**

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 4 pens Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Avonex Prefilled

**Products Affected**

- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 4 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Balsalazide Disodium

**Products Affected**

- *balsalazide disodium*

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

# Banzel

**Products Affected**

- BANZEL ORAL TABLET

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

# Bayer Breeze 2 Test

**Products Affected**

- BAYER BREEZE 2 TEST

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

# Bayer Contour Next Test

**Products Affected**

- BAYER CONTOUR NEXT TEST

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

# Bayer Contour Test

**Products Affected**

- BAYER CONTOUR TEST

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

# Beconase AQ

**Products Affected**

- BECONASE AQ

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

# Belsomra

**Products Affected**

- BELSOMRA

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

# Belviq

**Products Affected**

- BELVIQ

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

# Benlysta

**Products Affected**

- BENLYSTA INTRAVENOUS

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

# Benlysta

**Products Affected**

- BENLYSTA SUBCUTANEOUS

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

# Berinert

**Products Affected**

- BERINERT

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

# Betaseron

**Products Affected**

- BETASERON SUBCUTANEOUS KIT

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

# Bexarotene

**Products Affected**

- *bexarotene*

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

# Bicalutamide

**Products Affected**

- *bicalutamide*

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

# Bimatoprost

**Products Affected**

- *bimatoprost ophthalmic*

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

# Bosulif

**Products Affected**

- BOSULIF ORAL TABLET 100 MG

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

# Bosulif

**Products Affected**

- BOSULIF ORAL TABLET 500 MG

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

# Botox

**Products Affected**

- BOTOX

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

# Bravelle

**Products Affected**

- BRAVELLE

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

# Breo Ellipta

**Products Affected**

- BREO ELLIPTA

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

# Brilinta

**Products Affected**

- BRILINTA

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

# Brilinta

**Products Affected**

- BRILINTA

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

# Brovana

**Products Affected**

- BROVANA

| | |
|---|---|
| **QL Criteria** | 60 vials Per 1 fill |
| **Notes/ References** | Annual Review: 07/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Budesonide

**Products Affected**

- *budesonide inhalation*

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

# Bunavail

**Products Affected**

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

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

# Bunavail

**Products Affected**

- BUNAVAIL BUCCAL FILM 4.2-0.7 MG

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

# Bunavail

**Products Affected**

- BUNAVAIL BUCCAL FILM 6.3-1 MG

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

# Buphenyl

**Products Affected**

- BUPHENYL ORAL TABLET

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

# Buprenorphine

**Products Affected**

- *buprenorphine*

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

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

# Buprenorphine HCl

**Products Affected**

- *buprenorphine hcl sublingual*

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

# Buprenorphine HCl-Naloxone HCl

**Products Affected**

- *buprenorphine hcl-naloxone hcl*

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

# BuPROPion HCl

**Products Affected**

- *bupropion hcl oral*

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

# BuPROPion HCl ER (Smoking Det)

**Products Affected**

- *bupropion hcl er (smoking det)*

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

# BuPROPion HCl ER (SR)

**Products Affected**

- *bupropion hcl er (sr)*

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

# BuPROPion HCl ER (XL)

**Products Affected**

- *bupropion hcl er (xl)*

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

# Butalbital-APAP-Caff-Cod

**Products Affected**

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

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

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

# Butalbital-ASA-Caff-Codeine

**Products Affected**

- *butalbital-asa-caff-codeine*

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

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

# Butorphanol Tartrate

**Products Affected**

- *butorphanol tartrate nasal*

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

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

# Bydureon

**Products Affected**

- BYDUREON SUBCUTANEOUS PEN-INJECTOR

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

# Byetta 10 MCG Pen

**Products Affected**

- BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# Byetta 5 MCG Pen

**Products Affected**

- BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# Bystolic

**Products Affected**

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

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

# Bystolic

**Products Affected**

- BYSTOLIC ORAL TABLET 20 MG

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

# Calcipotriene

**Products Affected**

- *calcipotriene external*

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

# Calcipotriene-Betameth Diprop

**Products Affected**

- *calcipotriene-betameth diprop*

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

# Calcitonin (Salmon)

**Products Affected**

- *calcitonin (salmon)*

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

# Calcitrene

**Products Affected**

- *calcitrene*

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

# Canasa

**Products Affected**

- CANASA

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

# Candesartan Cilexetil

**Products Affected**

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

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

# Candesartan Cilexetil-HCTZ

**Products Affected**

- *candesartan cilexetil-hctz*

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

# Capecitabine

**Products Affected**

- *capecitabine*

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

# Caprelsa

**Products Affected**

- CAPRELSA ORAL TABLET 100 MG

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

# Caprelsa

**Products Affected**

- CAPRELSA ORAL TABLET 300 MG

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

# Carbaglu

**Products Affected**

- CARBAGLU

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

# Cardura XL

**Products Affected**

- CARDURA XL

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

# CareSens N Glucose Test

**Products Affected**

- CARESENS N GLUCOSE TEST

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

# Cartia XT

**Products Affected**

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

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

# Cartia XT

**Products Affected**

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

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

# Cayston

**Products Affected**

- CAYSTON

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

# Celecoxib

**Products Affected**

- *celecoxib oral*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two non steroidal anti-inflammatory drugs (NSAID) |
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cerdelga

**Products Affected**

- CERDELGA

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

# Cerezyme

**Products Affected**

- CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT

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

# Cesamet

**Products Affected**

- CESAMET

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

# Cetrotide

**Products Affected**

- CETROTIDE SUBCUTANEOUS KIT 0.25 MG

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

# Cevimeline HCl

**Products Affected**

- *cevimeline hcl*

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

# Chantix

**Products Affected**

- CHANTIX

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

# Chantix Continuing Month Pak

**Products Affected**

- CHANTIX CONTINUING MONTH PAK

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

# Chenodal

**Products Affected**

- CHENODAL

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

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# Chorionic Gonadotropin

**Products Affected**

- *chorionic gonadotropin intramuscular*

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

# Cialis

**Products Affected**

- CIALIS ORAL TABLET 5 MG

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

# Ciclodan

**Products Affected**

- *ciclodan external solution*

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

# Ciclopirox

**Products Affected**

- *ciclopirox external solution*

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

# Cimzia

**Products Affected**

- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

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

# Cimzia Prefilled

**Products Affected**

- CIMZIA PREFILLED

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

# Cimzia Starter Kit

**Products Affected**

- CIMZIA STARTER KIT

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

# Citalopram Hydrobromide

**Products Affected**

- *citalopram hydrobromide oral tablet*

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

# Citalopram Hydrobromide

**Products Affected**

- *citalopram hydrobromide oral tablet*

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

# Claravis

**Products Affected**

- *claravis*

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

# Clever Chek Auto-Code

**Products Affected**

- CLEVER CHEK AUTO-CODE

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

# Clever Chek Auto-Code Test

**Products Affected**

- CLEVER CHEK AUTO-CODE TEST

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

# Clever Chek Auto-Code Voice

**Products Affected**

- CLEVER CHEK AUTO-CODE VOICE IN VITRO

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

# Clever Chek Test

**Products Affected**

- CLEVER CHEK TEST

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

# Clever Choice Auto-Code Test

**Products Affected**

- CLEVER CHOICE AUTO-CODE TEST

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

# Clever Choice Micro Test

**Products Affected**

- CLEVER CHOICE MICRO TEST

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

# Climara Pro

**Products Affected**

- CLIMARA PRO

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

# CloNIDine HCl ER

**Products Affected**

- *clonidine hcl er*

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

# Clopidogrel Bisulfate

**Products Affected**

- *clopidogrel bisulfate oral*

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

# Clopidogrel Bisulfate

**Products Affected**

- *clopidogrel bisulfate oral*

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

# CloZAPine

**Products Affected**

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

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

# CloZAPine

**Products Affected**

- *clozapine oral tablet 200 mg*

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

# CloZAPine

**Products Affected**

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

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

# CloZAPine

**Products Affected**

- *clozapine oral tablet dispersible 12.5 mg*

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

# CloZAPine

**Products Affected**

- *clozapine oral tablet dispersible 150 mg*

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

# CloZAPine

**Products Affected**

- *clozapine oral tablet dispersible 200 mg*

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

# Codeine Sulfate

**Products Affected**

- *codeine sulfate oral tablet*

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

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

# Colchicine

**Products Affected**

- *colchicine oral tablet*

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

# CombiPatch

**Products Affected**

- COMBIPATCH

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

# Cometriq (100 mg Daily Dose)

**Products Affected**

- COMETRIQ (100 MG DAILY DOSE)

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

# Cometriq (140 mg Daily Dose)

**Products Affected**

- COMETRIQ (140 MG DAILY DOSE)

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

# Cometriq (60 mg Daily Dose)

**Products Affected**

- COMETRIQ (60 MG DAILY DOSE)

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

# Complera

**Products Affected**

- COMPLERA

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

# Contrave

**Products Affected**

- CONTRAVE

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

# Copaxone

**Products Affected**

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML

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

# Cordran

**Products Affected**

- CORDRAN EXTERNAL TAPE

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

# Coreg CR

**Products Affected**

- COREG CR

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

# Corlanor

**Products Affected**

- CORLANOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | FDA labeled use for heart failure |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, and who are on maximally tolerated doses of beta-blockers (bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate/metoprolol succinate-HCTZ, nevibolol) or have a documented contraindication to beta-blocker use. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of one month of a formualry ACE Inhibitor, ACE Inhibitor/HCTZ combination product, Angiotensin-Receptor Blocker, or Angiotensin-Receptor Blocker/HCTZ combination product |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cosopt PF

**Products Affected**

- COSOPT PF

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

# Creon

**Products Affected**

- CREON

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

# Crinone

**Products Affected**

- CRINONE VAGINAL GEL 4 %

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

# Crinone

**Products Affected**

- CRINONE VAGINAL GEL 8 %

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

# Cuvposa

**Products Affected**

- CUVPOSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | neurologic conditions associated with drooling (e.g. cerebral palsy) |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentaion of neurologic conditions associated with drooling (e.g. cerebral palsy) to reduce severe chronic drooling |
| **Age Restrictions** | 3 years to 16 years |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Cycloset

**Products Affected**

- CYCLOSET

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

# Cystagon

**Products Affected**

- CYSTAGON

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

# Cystaran

**Products Affected**

- CYSTARAN

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

# Dacogen

**Products Affected**

- DACOGEN

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

# Daklinza

**Products Affected**

- DAKLINZA

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

# Daliresp

**Products Affected**

- DALIRESP

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

# Darifenacin Hydrobromide ER

**Products Affected**

- *darifenacin hydrobromide er*

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

# Daytrana

**Products Affected**

- DAYTRANA

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

# Decitabine

**Products Affected**

- *decitabine*

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

# Delzicol

**Products Affected**

- DELZICOL

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Apriso |
| **QL Criteria** | 12 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Denavir

**Products Affected**

- DENAVIR

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

# Descovy

**Products Affected**

- DESCOVY

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

# Desloratadine

**Products Affected**

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

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

# Desloratadine

**Products Affected**

- *desloratadine oral tablet dispersible 5 mg*

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

# Desvenlafaxine Succinate ER

**Products Affected**

- *desvenlafaxine succinate er*

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

# Dexilant

**Products Affected**

- DEXILANT

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

| | |
|---|---|
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dexmethylphenidate HCl

**Products Affected**

- *dexmethylphenidate hcl*

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

# Dexmethylphenidate HCl ER

**Products Affected**

- *dexmethylphenidate hcl er*

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

# Dextroamphetamine Sulfate

**Products Affected**

- *dextroamphetamine sulfate oral solution*

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

# Dextroamphetamine Sulfate

**Products Affected**

- *dextroamphetamine sulfate oral tablet*

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

# Dextroamphetamine Sulfate ER

**Products Affected**

- *dextroamphetamine sulfate er*

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

# DiazePAM

**Products Affected**

- *diazepam rectal*

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

# Diclofenac Sodium

**Products Affected**

- *diclofenac sodium transdermal gel 1 %*

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

# Dificid

**Products Affected**

- DIFICID

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

# Diltiazem CD

**Products Affected**

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

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

# Diltiazem CD

**Products Affected**

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

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

# Diltiazem HCl ER

**Products Affected**

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

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

# Diltiazem HCl ER Beads

**Products Affected**

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

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

# Diltiazem HCl ER Beads

**Products Affected**

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

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

# Diltiazem HCl ER Beads

**Products Affected**

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

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

# Diltiazem HCl ER Coated Beads

**Products Affected**

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

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

# DilTIAZem HCl ER Coated Beads

**Products Affected**

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

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

# DilTIAZem HCl ER Coated Beads

**Products Affected**

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

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

# Dilt-XR

**Products Affected**

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

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

# Dipentum

**Products Affected**

- DIPENTUM

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

# Divigel

**Products Affected**

- DIVIGEL

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

# Donepezil HCl

**Products Affected**

- *donepezil hcl oral tablet 23 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of donepezil 10mg |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Doxycycline

**Products Affected**

- *doxycycline*

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

# Dronabinol

**Products Affected**

- *dronabinol*

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

# Duavee

**Products Affected**

- DUAVEE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Treatment of moderate to severe vasomotor symptoms associated with menopause,  Prevention of postmenopausal osteoporosis |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause or prevention of postmenopausal osteoporosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of estrogen products and raloxifene |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: October 12, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Dulera

**Products Affected**

- DULERA

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

# DULoxetine HCl

**Products Affected**

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

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

# DULoxetine HCl

**Products Affected**

- *duloxetine hcl oral capsule delayed release particles 30 mg*
- *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<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# DULoxetine HCl

**Products Affected**

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

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

# Dutasteride

**Products Affected**

- *dutasteride*

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

# Easy Plus II Glucose Test

**Products Affected**

- EASY PLUS II GLUCOSE TEST

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

# Easy Step Test

**Products Affected**

- EASY STEP TEST

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

# Easy Talk Blood Glucose Test

**Products Affected**

- EASY TALK BLOOD GLUCOSE TEST

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

# Easy Touch Test

**Products Affected**

- EASY TOUCH TEST

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

# Easy Trak Blood Glucose Test

**Products Affected**

- EASY TRAK BLOOD GLUCOSE TEST

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

# EasyGluco

**Products Affected**

- EASYGLUCO IN VITRO

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

# EasyMax 15 Test

**Products Affected**

- EASYMAX 15 TEST

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

# EASYMax Test

**Products Affected**

- EASYMAX TEST

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

# EasyPlus Blood Glucose Test

**Products Affected**

- EASYPLUS BLOOD GLUCOSE TEST

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

# EasyPRO Plus

**Products Affected**

- EASYPRO PLUS IN VITRO

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

# Edarbi

**Products Affected**

- EDARBI

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

# Edarbyclor

**Products Affected**

- EDARBYCLOR

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

# Edurant

**Products Affected**

- EDURANT

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

# Elaprase

**Products Affected**

- ELAPRASE

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

# Elelyso

**Products Affected**

- ELELYSO

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

# Element Test

**Products Affected**

- ELEMENT TEST

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

# Elestrin

**Products Affected**

- ELESTRIN

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

# Eletriptan Hydrobromide

**Products Affected**

- *eletriptan hydrobromide*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan |
| **QL Criteria** | 6 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Elidel

**Products Affected**

- ELIDEL

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

# Eliquis

**Products Affected**

- ELIQUIS

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

# Embeda

**Products Affected**

- EMBEDA

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

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

# Embrace Blood Glucose Test

**Products Affected**

- EMBRACE BLOOD GLUCOSE TEST

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

# Emsam

**Products Affected**

- EMSAM

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

# Emtriva

**Products Affected**

- EMTRIVA ORAL CAPSULE

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

# Enbrel

**Products Affected**

- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML

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

# Enbrel

**Products Affected**

- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML

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

# Enbrel SureClick

**Products Affected**

- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

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

# 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** | |
| **Coverage Duration** | Length of Therapy; see required medical information |

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

# Endometrin

**Products Affected**

- ENDOMETRIN

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

# Enoxaparin Sodium

**Products Affected**

- *enoxaparin sodium*

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

# Entecavir

**Products Affected**

- *entecavir*

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

# Epclusa

**Products Affected**

- EPCLUSA

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

# Epiduo Forte

**Products Affected**

- EPIDUO FORTE

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

# EPINEPHrine

**Products Affected**

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

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

# EPINEPHrine

**Products Affected**

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

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

# EpiPen 2-Pak

**Products Affected**

- EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR

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

# EpiPen Jr 2-Pak

**Products Affected**

- EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR

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

# Epogen

**Products Affected**

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

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

# Epoprostenol Sodium

**Products Affected**

- *epoprostenol sodium*

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

# Eprosartan Mesylate

**Products Affected**

- *eprosartan mesylate*

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

# Erivedge

**Products Affected**

- ERIVEDGE

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

# Escitalopram Oxalate

**Products Affected**

- *escitalopram oxalate oral tablet 10 mg*

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

# Escitalopram Oxalate

**Products Affected**

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

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

# Esomeprazole Magnesium

**Products Affected**

- *esomeprazole magnesium*

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

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

# Estradiol

**Products Affected**

- *estradiol transdermal patch twice weekly*

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

# Estradiol

**Products Affected**

- *estradiol transdermal patch weekly*

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

# Estradiol-Norethindrone Acet

**Products Affected**

- *estradiol-norethindrone acet*

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

# Estradiol-Norethindrone Acet

**Products Affected**

- *estradiol-norethindrone acet*

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

# Estrogel

**Products Affected**

- ESTROGEL

| | |
|---|---|
| **QL Criteria** | 50 grams Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Eszopiclone

**Products Affected**

- *eszopiclone*

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

# Evamist

**Products Affected**

- EVAMIST

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

# EvenCare + Blood Glucose Test

**Products Affected**

- EVENCARE + BLOOD GLUCOSE TEST

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

# EvenCare Blood Glucose Test

**Products Affected**

- EVENCARE BLOOD GLUCOSE TEST

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

# EvenCare G2 Test

**Products Affected**

- EVENCARE G2 TEST

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

# EvenCare G3 Test

**Products Affected**

- EVENCARE G3 TEST

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

# Evolution Autocode

**Products Affected**

- EVOLUTION AUTOCODE IN VITRO

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

# Exjade

**Products Affected**

- EXJADE

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

# Extavia

**Products Affected**

- EXTAVIA SUBCUTANEOUS KIT

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

# Ez Smart Blood Glucose Test

**Products Affected**

- EZ SMART BLOOD GLUCOSE TEST

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

# Ez Smart Plus Glucose Test

**Products Affected**

- EZ SMART PLUS GLUCOSE TEST

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

# Ezetimibe

**Products Affected**

- *ezetimibe*

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

# Ezetimibe-Simvastatin

**Products Affected**

- *ezetimibe-simvastatin*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastain |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fabrazyme

**Products Affected**

- FABRAZYME

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

# Famciclovir

**Products Affected**

- *famciclovir oral*

| | |
|---|---|
| **QL Criteria** | 21 tabs Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fanapt

**Products Affected**

- FANAPT

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Fanapt Titration Pack

**Products Affected**

- FANAPT TITRATION PACK

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Farxiga

**Products Affected**

- FARXIGA

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

# Felodipine ER

**Products Affected**

- *felodipine er*

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

# Femring

**Products Affected**

- FEMRING

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

# Fenofibrate

**Products Affected**

- *fenofibrate oral capsule*

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

# Fenofibrate

**Products Affected**

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

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

# Fenofibrate Micronized

**Products Affected**

- *fenofibrate micronized*

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

# Fenofibric Acid

**Products Affected**

- *fenofibric acid oral tablet*

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

# FentaNYL

**Products Affected**

- *fentanyl*

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

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

# FentaNYL Citrate

**Products Affected**

- *fentanyl citrate buccal*

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

# Ferriprox

**Products Affected**

- FERRIPROX

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

# Fetzima

**Products Affected**

- FETZIMA

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

# Fetzima Titration

**Products Affected**

- FETZIMA TITRATION

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

# Fifty50 Glucose Test 2.0

**Products Affected**

- FIFTY50 GLUCOSE TEST 2.0

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

# Firmagon

**Products Affected**

- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG

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

# First-Progesterone VGS 100

**Products Affected**

- FIRST-PROGESTERONE VGS 100

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

# First-Progesterone VGS 200

**Products Affected**

- FIRST-PROGESTERONE VGS 200

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

# Flebogamma DIF

**Products Affected**

- FLEBOGAMMA DIF

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

# Flovent Diskus

**Products Affected**

- FLOVENT DISKUS

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of QVAR |
| **QL Criteria** | 2 blisters Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: October 30, 2017 |

# Flovent HFA

**Products Affected**

- FLOVENT HFA

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

# Flowtuss

**Products Affected**

- FLOWTUSS

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

# FLUoxetine HCl

**Products Affected**

- *fluoxetine hcl oral capsule 10 mg*

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

# FLUoxetine HCl

**Products Affected**

- *fluoxetine hcl oral capsule 20 mg*

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

# FLUoxetine HCl

**Products Affected**

- *fluoxetine hcl oral capsule 40 mg*

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

# FLUoxetine HCl

**Products Affected**

- *fluoxetine hcl oral capsule delayed release*

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

# FLUoxetine HCl

**Products Affected**

- *fluoxetine hcl oral tablet 10 mg*

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

# FLUoxetine HCl

**Products Affected**

- *fluoxetine hcl oral tablet 20 mg*

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

# Fluticasone Propionate

**Products Affected**

- *fluticasone propionate nasal*

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

# Fluticasone-Salmeterol

**Products Affected**

- *fluticasone-salmeterol*

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

# Fluvastatin Sodium

**Products Affected**

- *fluvastatin sodium*

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

# Fluvastatin Sodium ER

**Products Affected**

- *fluvastatin sodium er*

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

# FluvoxaMINE Maleate

**Products Affected**

- *fluvoxamine maleate oral tablet 100 mg*

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

# FluvoxaMINE Maleate

**Products Affected**

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

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

# Follistim AQ

**Products Affected**

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

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

# Fondaparinux Sodium

**Products Affected**

- *fondaparinux sodium*

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

# FORA D10 2-in-1 Monitor

**Products Affected**

- FORA D10 2-IN-1 MONITOR

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

# FORA D15g 2-in-1 Monitor

**Products Affected**

- FORA D15G 2-IN-1 MONITOR

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

# FORA D15g Blood Glucose Test

**Products Affected**

- FORA D15G BLOOD GLUCOSE TEST

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

# FORA D20 2-in-1 Monitor

**Products Affected**

- FORA D20 2-IN-1 MONITOR

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

# FORA D20 Blood Glucose Test

**Products Affected**

- FORA D20 BLOOD GLUCOSE TEST

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

# FORA G20 Blood Glucose Test

**Products Affected**

- FORA G20 BLOOD GLUCOSE TEST

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

# FORA G30a Blood Glucose Test

**Products Affected**

- FORA G30A BLOOD GLUCOSE TEST

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

# Fora GD20 Test

**Products Affected**

- FORA GD20 TEST

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

# FORA V10 Blood Glucose Test

**Products Affected**

- FORA V10 BLOOD GLUCOSE TEST

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

# FORA V12 Blood Glucose Test

**Products Affected**

- FORA V12 BLOOD GLUCOSE TEST

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

# FORA V20 Blood Glucose Test

**Products Affected**

- FORA V20 BLOOD GLUCOSE TEST

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

# FORA V30a Blood Glucose Test

**Products Affected**

- FORA V30A BLOOD GLUCOSE TEST

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

# ForaCare GD40 Test

**Products Affected**

- FORACARE GD40 TEST

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

# ForaCare premium V10 Test

**Products Affected**

- FORACARE PREMIUM V10 TEST

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

# Forteo

**Products Affected**

- FORTEO SUBCUTANEOUS SOLUTION
  600 MCG/2.4ML

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

# Fosamax Plus D

**Products Affected**

- FOSAMAX PLUS D

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

# Fragmin

**Products Affected**

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

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

# FreeStyle InsuLinx Test

**Products Affected**

- FREESTYLE INSULINX TEST

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

# FreeStyle Lite Test

**Products Affected**

- FREESTYLE LITE TEST

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

# FreeStyle Test

**Products Affected**

- FREESTYLE TEST

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

# Frovatriptan Succinate

**Products Affected**

- *frovatriptan succinate*

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

# Fycompa

**Products Affected**

- FYCOMPA ORAL TABLET

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gabapentin

**Products Affected**

- *gabapentin oral capsule*

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

# Gabapentin

**Products Affected**

- *gabapentin oral solution 250 mg/5ml*

| | |
|---|---|
| **QL Criteria** | 40 ml Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gabapentin

**Products Affected**

- *gabapentin oral tablet*

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

# Gammaplex

**Products Affected**

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

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

# Gamunex-C

**Products Affected**

- GAMUNEX-C

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

# Ganirelix Acetate

**Products Affected**

- *ganirelix acetate*

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

# Gattex

**Products Affected**

- GATTEX

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

# GE100 Blood Glucose Test

**Products Affected**

- GE100 BLOOD GLUCOSE TEST

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

# Gelnique

**Products Affected**

- GELNIQUE TRANSDERMAL GEL 10 %

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

# Genvoya

**Products Affected**

- GENVOYA

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

# Giazo

**Products Affected**

- GIAZO

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of balsalazide |
| **QL Criteria** | 6 tabs Per 1 Day |
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gilenya

**Products Affected**

- GILENYA

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

# Gilotrif

**Products Affected**

- GILOTRIF

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

# Glatopa

**Products Affected**

- GLATOPA

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

# GlucaGen Diagnostic

**Products Affected**

- GLUCAGEN DIAGNOSTIC

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

# GlucaGen HypoKit

**Products Affected**

- GLUCAGEN HYPOKIT

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

# Glucocard 01 Sensor Plus

**Products Affected**

- GLUCOCARD 01 SENSOR PLUS

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

# Glucocard Expression Test

**Products Affected**

- GLUCOCARD EXPRESSION TEST

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

# Glucocard Vital Test

**Products Affected**

- GLUCOCARD VITAL TEST

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

# Glucocard X-Sensor

**Products Affected**

- GLUCOCARD X-SENSOR

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

# GlucoCom Test

**Products Affected**

- GLUCOCOM TEST

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

# Glyxambi

**Products Affected**

- GLYXAMBI

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Tradjenta or Jentadueto and either Januvia or Janumet |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Gonal-f

**Products Affected**

- GONAL-F

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

# Gonal-f RFF

**Products Affected**

- GONAL-F RFF

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

# Gonal-f RFF Rediject

**Products Affected**

- GONAL-F RFF REDIJECT

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

# Gralise

**Products Affected**

- GRALISE ORAL TABLET 300 MG

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

# Gralise

**Products Affected**

- GRALISE ORAL TABLET 600 MG

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

# Gralise Starter

**Products Affected**

- GRALISE STARTER

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

# Grastek

**Products Affected**

- GRASTEK

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

# GuanFACINE HCl ER

**Products Affected**

- *guanfacine hcl er*

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

# Guardian REAL-Time System Ped

**Products Affected**

- GUARDIAN REAL-TIME SYSTEM PED

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

# Halaven

**Products Affected**

- HALAVEN

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

# Harvoni

**Products Affected**

- HARVONI

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

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

# Hemangeol

**Products Affected**

- HEMANGEOL

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

# Hetlioz

**Products Affected**

- HETLIOZ

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

# Horizant

**Products Affected**

- HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG

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

# Horizant

**Products Affected**

- HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG

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

# Humira

**Products Affected**

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

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

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

# Humira Pediatric Crohns Start

**Products Affected**

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML

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

# Humira Pen

**Products Affected**

- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT

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

# Humira Pen-Crohns Starter

**Products Affected**

- HUMIRA PEN-CROHNS STARTER SUBCUTANEOUS PEN-INJECTOR KIT

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

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

# Hycamtin

**Products Affected**

- HYCAMTIN ORAL

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

# Hydrocodone-Acetaminophen

**Products Affected**

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

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

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

# Hydrocodone-Acetaminophen

**Products Affected**

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

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

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

# Hydrocodone-Ibuprofen

**Products Affected**

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

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

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

# HYDROmorphone HCl

**Products Affected**

- *hydromorphone hcl oral tablet*

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

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

# HYDROmorphone HCl

**Products Affected**

- *hydromorphone hcl rectal*

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

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

# HYDROmorphone HCl ER

**Products Affected**

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

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

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

# HYDROmorphone HCl ER

**Products Affected**

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

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

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

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

# Ibandronate Sodium

**Products Affected**

- *ibandronate sodium oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Osteoporosis |
| **Exclusion Criteria** | No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates. |
| **Required Medical Information** | A documented diagnosis of osteoporosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg |
| **QL Criteria** | 1 tab Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ibrance

**Products Affected**

- IBRANCE

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

# Ibudone

**Products Affected**

- *ibudone oral tablet 5-200 mg*

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

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

# Iclusig

**Products Affected**

- ICLUSIG ORAL TABLET 15 MG

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

# Iclusig

**Products Affected**

- ICLUSIG ORAL TABLET 45 MG

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

# Ilaris

**Products Affected**

- ILARIS

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

# Ilaris (150mg Delivered)

**Products Affected**

- ILARIS (150MG DELIVERED)

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

# Imatinib Mesylate

**Products Affected**

- *imatinib mesylate*

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

# Imiquimod

**Products Affected**

- *imiquimod external*

| | |
|---|---|
| **QL Criteria** | 48 packets Per 365 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Increlex

**Products Affected**

- INCRELEX

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

# Incruse Ellipta

**Products Affected**

- INCRUSE ELLIPTA

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

# Indomethacin

**Products Affected**

- *indomethacin oral*

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

# Infinity Blood Glucose Test

**Products Affected**

- INFINITY BLOOD GLUCOSE TEST

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

# Inlyta

**Products Affected**

- INLYTA

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

# Intelence

**Products Affected**

- INTELENCE ORAL TABLET 100 MG, 25 MG

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

# Intelence

**Products Affected**

- INTELENCE ORAL TABLET 200 MG

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

# Intron A

**Products Affected**

- INTRON A

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

# Invokamet

**Products Affected**

- INVOKAMET

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

# Invokamet XR

**Products Affected**

- INVOKAMET XR

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

# Invokana

**Products Affected**

- INVOKANA

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

# Ipratropium Bromide

**Products Affected**

- *ipratropium bromide nasal*

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

# Irbesartan

**Products Affected**

- *irbesartan*

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

# Irbesartan-Hydrochlorothiazide

**Products Affected**

- *irbesartan-hydrochlorothiazide*

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

# Isentress

**Products Affected**

- ISENTRESS ORAL TABLET

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

# Isentress

**Products Affected**

- ISENTRESS ORAL TABLET CHEWABLE

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

# Isentress HD

**Products Affected**

- ISENTRESS HD

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

# Itraconazole

**Products Affected**

- *itraconazole oral*

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

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

# Jakafi

**Products Affected**

- JAKAFI

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

# Jakafi

**Products Affected**

- JAKAFI

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

# Janumet

**Products Affected**

- JANUMET

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

# Janumet XR

**Products Affected**

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

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

# Janumet XR

**Products Affected**

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

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

# Januvia

**Products Affected**

- JANUVIA

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

# Jardiance

**Products Affected**

- JARDIANCE

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

# Jentadueto

**Products Affected**

- JENTADUETO

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

# Jentadueto XR

**Products Affected**

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

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

# Jentadueto XR

**Products Affected**

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

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

# Jevtana

**Products Affected**

- JEVTANA

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

# Jublia

**Products Affected**

- JUBLIA

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

# Juxtapid

**Products Affected**

- JUXTAPID ORAL CAPSULE 10 MG, 5 MG

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

# Juxtapid

**Products Affected**

- JUXTAPID ORAL CAPSULE 20 MG

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

# Juxtapid

**Products Affected**

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

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

# Kadian

**Products Affected**

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

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

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

# Kalydeco

**Products Affected**

- KALYDECO

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

# Kalydeco

**Products Affected**

- KALYDECO

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

# Kepivance

**Products Affected**

- KEPIVANCE

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

# Kerydin

**Products Affected**

- KERYDIN

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

# Ketoconazole

**Products Affected**

- *ketoconazole oral*

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

# Ketorolac Tromethamine

**Products Affected**

- *ketorolac tromethamine oral*

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

# Kineret

**Products Affected**

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

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

# Kogenate FS Bio-Set

**Products Affected**

- KOGENATE FS BIO-SET

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

# Kombiglyze XR

**Products Affected**

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

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

# Kombiglyze XR

**Products Affected**

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

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

# Korlym

**Products Affected**

- KORLYM

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

# Kroger Blood Glucose Test

**Products Affected**

- KROGER BLOOD GLUCOSE TEST

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

# Kroger Premium Glucose Test

**Products Affected**

- KROGER PREMIUM GLUCOSE TEST

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

# Kroger Test

**Products Affected**

- KROGER TEST

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

# Kuvan

**Products Affected**

- KUVAN ORAL PACKET 500 MG
- KUVAN ORAL TABLET SOLUBLE

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

# LamoTRIgine

**Products Affected**

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

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

# LamoTRIgine

**Products Affected**

- *lamotrigine oral tablet dispersible 25 mg*

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

# LamoTRIgine

**Products Affected**

- *lamotrigine oral tablet dispersible 50 mg*

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

# LamoTRIgine ER

**Products Affected**

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

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

# LamoTRIgine ER

**Products Affected**

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

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

# LamoTRIgine ER

**Products Affected**

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

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

# Lansoprazole

**Products Affected**

- *lansoprazole oral capsule delayed release 15 mg*

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

# Lansoprazole

**Products Affected**

- *lansoprazole oral capsule delayed release 30 mg*

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

# Lantus

**Products Affected**

- LANTUS

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

# Lantus SoloStar

**Products Affected**

- LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# Latuda

**Products Affected**

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

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Latuda

**Products Affected**

- LATUDA ORAL TABLET 60 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Latuda

**Products Affected**

- LATUDA ORAL TABLET 80 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Leflunomide

**Products Affected**

- *leflunomide oral*

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

# Lemtrada

**Products Affected**

- LEMTRADA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 999 ML Per 999 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Letairis

**Products Affected**

- LETAIRIS

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

# Leukine

**Products Affected**

- LEUKINE INTRAVENOUS

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

# Leuprolide Acetate

**Products Affected**

- *leuprolide acetate injection*

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

# LevETIRAcetam ER

**Products Affected**

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

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

# LevETIRAcetam ER

**Products Affected**

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

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

# Levorphanol Tartrate

**Products Affected**

- *levorphanol tartrate oral*

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

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

# Liberty Next Generation Test

**Products Affected**

- LIBERTY NEXT GENERATION TEST

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

# Liberty Test

**Products Affected**

- LIBERTY TEST

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

# Lidocaine

**Products Affected**

- *lidocaine external ointment*

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

# Lidocaine

**Products Affected**

- *lidocaine external patch 5 %*

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

# Lidocaine-Prilocaine

**Products Affected**

- *lidocaine-prilocaine external cream*

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

# Linezolid

**Products Affected**

- *linezolid oral suspension reconstituted*

| | |
|---|---|
| **QL Criteria** | 150 ml Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Linezolid

**Products Affected**

- *linezolid oral tablet*

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

# Linzess

**Products Affected**

- LINZESS

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

# Linzess

**Products Affected**

- LINZESS

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

# Livalo

**Products Affected**

- LIVALO

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following:  atorvastatin, lovastatin, pravastatin, simvastain |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Lorcet

**Products Affected**

- *lorcet*

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

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

# Lorcet HD

**Products Affected**

- *lorcet hd*

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

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

# Losartan Potassium

**Products Affected**

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

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

# Lovastatin

**Products Affected**

- *lovastatin*

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

# Lumigan

**Products Affected**

- LUMIGAN OPHTHALMIC SOLUTION
  0.01 %

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

# Lumizyme

**Products Affected**

- LUMIZYME

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

# Lupaneta Pack

**Products Affected**

- LUPANETA PACK

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

# Lupron Depot (1-Month)

**Products Affected**

- LUPRON DEPOT (1-MONTH)

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

# Lupron Depot (3-Month)

**Products Affected**

- LUPRON DEPOT (3-MONTH)

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

# Lupron Depot (4-Month)

**Products Affected**

- LUPRON DEPOT (4-MONTH)

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

# Lupron Depot (6-Month)

**Products Affected**

- LUPRON DEPOT (6-MONTH)

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

# Lupron Depot-Ped (1-Month)

**Products Affected**

- LUPRON DEPOT-PED (1-MONTH)

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

# Lupron Depot-Ped (3-Month)

**Products Affected**

- LUPRON DEPOT-PED (3-MONTH)

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

# Lyrica

**Products Affected**

- LYRICA

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

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

# Maprotiline HCl

**Products Affected**

- *maprotiline hcl oral tablet 25 mg*

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

# Maprotiline HCl

**Products Affected**

- *maprotiline hcl oral tablet 50 mg*

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

# Maprotiline HCl

**Products Affected**

- *maprotiline hcl oral tablet 75 mg*

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

# Matzim LA

**Products Affected**

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

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

# Matzim LA

**Products Affected**

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

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

# Mavyret

**Products Affected**

- MAVYRET

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

# Meijer Blood Glucose Test

**Products Affected**

- MEIJER BLOOD GLUCOSE TEST

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

# Meijer Premium Glucose Test

**Products Affected**

- MEIJER PREMIUM GLUCOSE TEST

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

# Mekinist

**Products Affected**

- MEKINIST ORAL TABLET 0.5 MG

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

# Mekinist

**Products Affected**

- MEKINIST ORAL TABLET 2 MG

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

# Memantine HCl

**Products Affected**

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

# Menopur

**Products Affected**

- MENOPUR

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

# Menostar

**Products Affected**

- MENOSTAR

| | |
|---|---|
| **QL Criteria** | 4 patches Per 28 fills |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Meperidine HCl

**Products Affected**

- *meperidine hcl oral tablet*

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

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

# Mesalamine

**Products Affected**

- *mesalamine oral tablet delayed release 1.2 gm*

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

# Mesalamine

**Products Affected**

- *mesalamine oral tablet delayed release 800 mg*

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

# Metadate ER

**Products Affected**

- *metadate er oral tablet extended release 20 mg*

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

# MetFORMIN HCl ER (OSM)

**Products Affected**

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

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

# MetFORMIN HCl ER (OSM)

**Products Affected**

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

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

# Methadone HCl

**Products Affected**

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

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

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

# Methadone HCl

**Products Affected**

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

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

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

# Methadone HCl

**Products Affected**

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

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

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

# Methadone HCl

**Products Affected**

- *methadone hcl oral tablet*

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

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

# Methadone HCl Intensol

**Products Affected**

- *methadone hcl intensol*

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

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

# Methamphetamine HCl

**Products Affected**

- *methamphetamine hcl*

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

# Methylphenidate HCl

**Products Affected**

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

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

# Methylphenidate HCl

**Products Affected**

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

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

# Methylphenidate HCl

**Products Affected**

- *methylphenidate hcl oral tablet*

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

# Methylphenidate HCl

**Products Affected**

- *methylphenidate hcl oral tablet chewable*

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

# Methylphenidate HCl ER

**Products Affected**

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

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

# Methylphenidate HCl ER

**Products Affected**

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

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

# Methylphenidate HCl ER

**Products Affected**

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

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

# Methylphenidate HCl ER

**Products Affected**

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

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

# Methylphenidate HCl ER

**Products Affected**

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

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

# Methylphenidate HCl ER

**Products Affected**

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

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

# Methylphenidate HCl ER (CD)

**Products Affected**

- *methylphenidate hcl er (cd)*

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

# Methylphenidate HCl ER (LA)

**Products Affected**

- *methylphenidate hcl er (la)*

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

# Methylphenidate HCl ER (LA)

**Products Affected**

- *methylphenidate hcl er (la)*

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

# Metoprolol Succinate ER

**Products Affected**

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

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

# Metoprolol Succinate ER

**Products Affected**

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

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

# Metoprolol Succinate ER

**Products Affected**

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

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

# Miacalcin

**Products Affected**

- MIACALCIN INJECTION

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

# Microdot Test

**Products Affected**

- MICRODOT TEST

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

# Mimvey

**Products Affected**

- *mimvey*

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

# Mimvey Lo

**Products Affected**

- MIMVEY LO

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

# Mircera

**Products Affected**

- MIRCERA INJECTION SOLUTION PREFILLED SYRINGE

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

# Mirtazapine

**Products Affected**

- *mirtazapine oral*

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

# Mirtazapine

**Products Affected**

- *mirtazapine oral*

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

# Mirvaso

**Products Affected**

- MIRVASO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | persistent (nontransient) facial erythema of acne rosacea |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of persistent (nontransient) facial erythema of acne rosacea |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented step through topical metronidazole |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: October 13, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Modafinil

**Products Affected**

- *modafinil*

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

| | |
|---|---|
| **ST Criteria** | FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: A documented contraindication, intolerance, allergy, or failure of an adequate trial of at least two immediate release stimulants. |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: June 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Montelukast Sodium

**Products Affected**

- *montelukast sodium oral*

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

# Montelukast Sodium

**Products Affected**

- *montelukast sodium oral*

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

# Morphine Sulfate

**Products Affected**

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

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

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

# Morphine Sulfate

**Products Affected**

- *morphine sulfate oral tablet*

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

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

# Morphine Sulfate (Concentrate)

**Products Affected**

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

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

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

# Morphine Sulfate ER

**Products Affected**

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

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

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

# Morphine Sulfate ER

**Products Affected**

- *morphine sulfate er oral tablet extended release*

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

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

# Morphine Sulfate ER

**Products Affected**

- *morphine sulfate er oral tablet extended release*

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

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

# Morphine Sulfate ER Beads

**Products Affected**

- *morphine sulfate er beads*

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

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

# Mozobil

**Products Affected**

- MOZOBIL

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

# Multaq

**Products Affected**

- MULTAQ

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

# MyGlucoHealth Test

**Products Affected**

- MYGLUCOHEALTH TEST

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

# Myobloc

**Products Affected**

- MYOBLOC

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

# Myorisan

**Products Affected**

- *myorisan oral capsule 10 mg, 20 mg, 40 mg*

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

# Myrbetriq

**Products Affected**

- MYRBETRIQ

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

# Mytesi

**Products Affected**

- MYTESI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Diarrhea |
| **Exclusion Criteria** | |
| **Required Medical Information** | Covered for adult members who meet the following criteria: (1) Diagnosis of noninfectious diarrhea associated with HIV/AIDS infection that has lasted at least for one month, and (2) Currently stable on anti-retroviral therapy, and (3) Documentation of unsatisfactory effects with, intolerability to, or inability to take at least one anti-motility agent (loperamide, diphenoxylate/atropine, bismuth subsalicylate)or one or more watery bowel movements per day without regular ADM use. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of at least one antimotility agent such as loperamide or atropine/diphenoxylate |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: May 25, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Naftifine HCl

**Products Affected**

- *naftifine hcl*

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

# Naftin

**Products Affected**

- NAFTIN EXTERNAL GEL 1 %

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

# Naglazyme

**Products Affected**

- NAGLAZYME

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

# Namenda XR

**Products Affected**

- NAMENDA XR

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

# Namenda XR Titration Pack

**Products Affected**

- NAMENDA XR TITRATION PACK

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

# Namzaric

**Products Affected**

- NAMZARIC

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

# Naratriptan HCl

**Products Affected**

- *naratriptan hcl*

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

# Neulasta

**Products Affected**

- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

# Neupogen

**Products Affected**

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

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

# Neupro

**Products Affected**

- NEUPRO

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

# Neutek 2Tek Glucose/Pressure

**Products Affected**

- NEUTEK 2TEK GLUCOSE/PRESSURE

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

# Neutek 2Tek Test

**Products Affected**

- NEUTEK 2TEK TEST

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

# Nevirapine ER

**Products Affected**

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

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

# Nevirapine ER

**Products Affected**

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

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

# NexAVAR

**Products Affected**

- NEXAVAR

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

# NexIUM

**Products Affected**

- NEXIUM ORAL PACKET

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

| | |
|---|---|
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# NexIUM 24HR

**Products Affected**

- NEXIUM 24HR ORAL CAPSULE DELAYED RELEASE

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

# Nicotine Polacrilex

**Products Affected**

- *nicotine polacrilex mouth/throat gum*

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

# Nicotine Polacrilex

**Products Affected**

- *nicotine polacrilex mouth/throat lozenge*

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

# Nicotrol

**Products Affected**

- NICOTROL

| | |
|---|---|
| **QL Criteria** | 16 cartridges Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nicotrol NS

**Products Affected**

- NICOTROL NS

| | |
|---|---|
| **QL Criteria** | 12 bottles Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nifediac CC

**Products Affected**

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

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

# Nifedical XL

**Products Affected**

- *nifedical xl oral tablet extended release 24 hour 60 mg*

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

# NIFEdipine ER

**Products Affected**

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

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

# NIFEdipine ER

**Products Affected**

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

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

# NIFEdipine ER Osmotic Release

**Products Affected**

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

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

# NIFEdipine ER Osmotic Release

**Products Affected**

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

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

# Nisoldipine ER

**Products Affected**

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

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

# Nisoldipine ER

**Products Affected**

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

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

# Noritate

**Products Affected**

- NORITATE

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of metronidazole gel and metronidazole cream 0.75% |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nova Max Glucose Test

**Products Affected**

- NOVA MAX GLUCOSE TEST

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

# Novarel

**Products Affected**

- *novarel intramuscular solution reconstituted 10000 unit*

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

# NovoLOG

**Products Affected**

- NOVOLOG

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

# NovoLOG FlexPen

**Products Affected**

- NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

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

# NovoLOG Mix 70/30

**Products Affected**

- NOVOLOG MIX 70/30

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

# NovoLOG Mix 70/30 FlexPen

**Products Affected**

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

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

# NovoLOG PenFill

**Products Affected**

- NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE

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

# Noxafil

**Products Affected**

- NOXAFIL ORAL SUSPENSION

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

| | |
|---|---|
| **ST Criteria** | FOR A DIAGNOSIS OF INVASIVE CANDIDIASIS: A documented contraindication, intolerance, allergy, or failure of fluconazole. FOR A DIAGNOSIS OF OROPHARYNGEAL CANDIDIASIS: A documented contraindication, intolerance, allergy, or failure of fluconazole or itraconazole |
| **Notes/ References** | Annual Review: 09/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Nplate

**Products Affected**

- NPLATE

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

# Nucynta

**Products Affected**

- NUCYNTA

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

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

# Nucynta ER

**Products Affected**

- NUCYNTA ER

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

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

# Nuedexta

**Products Affected**

- NUEDEXTA

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

# Nulojix

**Products Affected**

- NULOJIX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/2017/ID/Nulojix.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: November 17, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Octagam

**Products Affected**

- OCTAGAM

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

# Octreotide Acetate

**Products Affected**

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

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

# Odefsey

**Products Affected**

- ODEFSEY

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

# Odomzo

**Products Affected**

- ODOMZO

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

# OLANZapine

**Products Affected**

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

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

# OLANZapine

**Products Affected**

- *olanzapine oral tablet 2.5 mg*

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

# OLANZapine

**Products Affected**

- *olanzapine oral tablet dispersible*

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

# OLANZapine-FLUoxetine HCl

**Products Affected**

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

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

# Olmesartan Medoxomil

**Products Affected**

- *olmesartan medoxomil oral*

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

# Olmesartan Medoxomil-HCTZ

**Products Affected**

- *olmesartan medoxomil-hctz*

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

# Olmesartan-Amlodipine-HCTZ

**Products Affected**

- *olmesartan-amlodipine-hctz*

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

# Omega-3-acid Ethyl Esters

**Products Affected**

- *omega-3-acid ethyl esters*

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

# Omeprazole-Sodium Bicarbonate

**Products Affected**

- *omeprazole-sodium bicarbonate oral capsule 20-1100 mg*

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

# Omnaris

**Products Affected**

- OMNARIS

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

# Omnitrope

**Products Affected**

- OMNITROPE SUBCUTANEOUS SOLUTION

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

# Omnitrope

**Products Affected**

- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

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

# On Call Plus Blood Glucose

**Products Affected**

- ON CALL PLUS BLOOD GLUCOSE

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

# On Call Vivid Blood Glucose

**Products Affected**

- ON CALL VIVID BLOOD GLUCOSE

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

# OneTouch Ultra Blue

**Products Affected**

- ONETOUCH ULTRA BLUE

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

# OneTouch Verio

**Products Affected**

- ONETOUCH VERIO IN VITRO STRIP

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

# Onfi

**Products Affected**

- ONFI ORAL TABLET 10 MG, 20 MG

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

# Onglyza

**Products Affected**

- ONGLYZA

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

# Opana ER

**Products Affected**

- OPANA ER ORAL TABLET ER 12 HOUR ABUSE-DETERRENT

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

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

# Opsumit

**Products Affected**

- OPSUMIT

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

# Oravig

**Products Affected**

- ORAVIG

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

# Orencia

**Products Affected**

- ORENCIA INTRAVENOUS

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

# Orencia

**Products Affected**

- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML

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

# Orencia

**Products Affected**

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

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

# Orencia ClickJect

**Products Affected**

- ORENCIA CLICKJECT

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

# Orenitram

**Products Affected**

- ORENITRAM

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

# Orfadin

**Products Affected**

- ORFADIN

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

# Orkambi

**Products Affected**

- ORKAMBI

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

# Oseltamivir Phosphate

**Products Affected**

- *oseltamivir phosphate oral capsule*

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

# Osphena

**Products Affected**

- OSPHENA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | moderate to severe dyspareunia |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of moderate to severe dyspareunia in a female patient |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of an estrogen product such as estradiol, estropipate, or Premarin |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 30, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Otezla

**Products Affected**

- OTEZLA ORAL TABLET

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

# Otezla

**Products Affected**

- OTEZLA ORAL TABLET THERAPY PACK

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

# Ovidrel

**Products Affected**

- OVIDREL

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

# Oxaydo

**Products Affected**

- OXAYDO

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

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

# Oxtellar XR

**Products Affected**

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

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

# Oxtellar XR

**Products Affected**

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 600 MG

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

# Oxybutynin Chloride

**Products Affected**

- *oxybutynin chloride oral tablet*

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

# Oxybutynin Chloride ER

**Products Affected**

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

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

# Oxybutynin Chloride ER

**Products Affected**

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

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

# OxyCODONE HCl

**Products Affected**

- *oxycodone hcl oral capsule*

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

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

# OxyCODONE HCl

**Products Affected**

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

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

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

# OxyCODONE HCl

**Products Affected**

- *oxycodone hcl oral tablet*

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

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyCODONE HCl ER

**Products Affected**

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxycodone-Acetaminophen

**Products Affected**

- *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxycodone-Aspirin

**Products Affected**

- *oxycodone-aspirin oral tablet 4.8355-325 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxycodone-Ibuprofen

**Products Affected**

- *oxycodone-ibuprofen*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyCONTIN

**Products Affected**

- OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Xtampza ER |
| **QL Criteria** | 4 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Oxymorphone HCl

**Products Affected**

- *oxymorphone hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two immediate-release opioids such as morphine, oxycodone, or hydromorphone. |
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# OxyMORphone HCl ER

**Products Affected**

- *oxymorphone hcl er*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of extended release morphine sulfate tablets (generic MS Contin) |
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Paliperidone ER

**Products Affected**

- *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Paliperidone ER

**Products Affected**

- *paliperidone er oral tablet extended release 24 hour 9 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 1 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pamidronate Disodium

**Products Affected**

- *pamidronate disodium*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pancreaze

**Products Affected**

- PANCREAZE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Exocrine pancreatic Insufficiency |
| **Exclusion Criteria** | Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use). |
| **Required Medical Information** | Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep |
| **Notes/ References** | Annual Review: 07/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Paricalcitol

**Products Affected**

- *paricalcitol oral*

| | |
|---|---|
| **QL Criteria** | 1 capsule Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# PARoxetine HCl

**Products Affected**

- *paroxetine hcl oral tablet 10 mg, 20 mg*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# PARoxetine HCl

**Products Affected**

- *paroxetine hcl oral tablet 30 mg, 40 mg*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# PARoxetine HCl ER

**Products Affected**

- *paroxetine hcl er*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of paroxetine |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pegasys

**Products Affected**

- PEGASYS SUBCUTANEOUS SOLUTION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pegasys ProClick

**Products Affected**

- PEGASYS PROCLICK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pentasa

**Products Affected**

- PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Apriso |
| **QL Criteria** | 16 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pentasa

**Products Affected**

- PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Apriso |
| **QL Criteria** | 8 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pentazocine-Naloxone HCl

**Products Affected**

- *pentazocine-naloxone hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Perforomist

**Products Affected**

- PERFOROMIST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Chronic Obstructive Pulmonary Disease (COPD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented physical limitation that prevents the use of a non-nebulized long-acting bronchodilator with or without use of a spacer |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 60 vials Per 1 fill |
| **Notes/ References** | Annual Review: 07/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pertzye

**Products Affected**

- PERTZYE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Exocrine pancreatic Insufficiency |
| **Exclusion Criteria** | Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use). |
| **Required Medical Information** | Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep |
| **Notes/ References** | Annual Review: 07/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pharmacist Choice Autocode

**Products Affected**

- PHARMACIST CHOICE AUTOCODE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Phenoxybenzamine HCl

**Products Affected**

- *phenoxybenzamine hcl oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/antihypertensive_misc.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Picato

**Products Affected**

- PICATO

| | |
|---|---|
| **QL Criteria** | 1 box Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pioglitazone HCl

**Products Affected**

- *pioglitazone hcl*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pioglitazone HCl-Glimepiride

**Products Affected**

- *pioglitazone hcl-glimepiride*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pioglitazone HCl-Metformin HCl

**Products Affected**

- *pioglitazone hcl-metformin hcl*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Plegridy

**Products Affected**

- PLEGRIDY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 2 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Plegridy

**Products Affected**

- PLEGRIDY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 2 syringes Per 28 months |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Plegridy Starter Pack

**Products Affected**

- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 1 kit Per 365 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Plegridy Starter Pack

**Products Affected**

- PLEGRIDY STARTER PACK
  SUBCUTANEOUS SOLUTION
  PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 2 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# PocketChem EZ Test

**Products Affected**

- POCKETCHEM EZ TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pomalyst

**Products Affected**

- POMALYST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Praluent

**Products Affected**

- PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 2 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pramipexole Dihydrochloride ER

**Products Affected**

- *pramipexole dihydrochloride er*

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prasugrel HCl

**Products Affected**

- *prasugrel hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Acute coronary syndrome (ACS) managed with percutaneous coronary intervention which includes unstable angina or non-ST elevation myocardial infarction or ST elevation myocardial infarction (MI) |
| **Exclusion Criteria** | History of Stroke or transient ischemic attack (TIA) |
| **Required Medical Information** | Member has a documented diagnosis of acute coronary syndrome (ACS) and is managed by percutaneous coronary intervention (PCI), which includes unstable angina, non-ST-elevation myocardial infarction (NSTEMI), or ST -elevation myocardial infarction (STEMI) managed with primary or delayed PCI and member has no prior history of stroke or transient ischemic attack (TIA) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 08, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pravastatin Sodium

**Products Affected**

- *pravastatin sodium*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision PCx

**Products Affected**

- PRECISION PCX

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision PCX Plus Test

**Products Affected**

- PRECISION PCX PLUS TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision Point of Care Test

**Products Affected**

- PRECISION POINT OF CARE TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision QID Test

**Products Affected**

- PRECISION QID TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision Sof-Tact Test

**Products Affected**

- PRECISION SOF-TACT TEST

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Precision Xtra Blood Glucose

**Products Affected**

- PRECISION XTRA BLOOD GLUCOSE

| | |
|---|---|
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prefest

**Products Affected**

- PREFEST

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pregnyl

**Products Affected**

- PREGNYL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/infertility.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prezista

**Products Affected**

- PREZISTA ORAL SUSPENSION

| | |
|---|---|
| **QL Criteria** | 2 bottles Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prezista

**Products Affected**

- PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prezista

**Products Affected**

- PREZISTA ORAL TABLET 800 MG

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Procrit

**Products Affected**

- PROCRIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Erythropoiesis_Stimulating_Agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prodigy No Coding Blood Gluc

**Products Affected**

- PRODIGY NO CODING BLOOD GLUC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Progesterone Micronized

**Products Affected**

- *progesterone micronized oral*

| | |
|---|---|
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prolastin-C

**Products Affected**

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Proleukin

**Products Affected**

- PROLEUKIN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Interleukin 2.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prolia

**Products Affected**

- PROLIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Promacta

**Products Affected**

- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Promacta.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Propafenone HCl ER

**Products Affected**

- *propafenone hcl er*

| | |
|---|---|
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Prudoxin

**Products Affected**

- PRUDOXIN

| | |
|---|---|
| **QL Criteria** | 45 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pulmicort Flexhaler

**Products Affected**

- PULMICORT FLEXHALER

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of QVAR |
| **QL Criteria** | 1 inhaler Per 1 month |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Pulmozyme

**Products Affected**

- PULMOZYME

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/cystic_fibrosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 60 units Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Qnasl

**Products Affected**

- QNASL

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Qnasl Childrens

**Products Affected**

- QNASL CHILDRENS

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Qsymia

**Products Affected**

- QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Body Mass Index (BMI) greater than 30kg/m2 or BMI greater than 27kg/m2 with one or more of the items in the required medical information section |
| **Exclusion Criteria** | Concomitant use of two or more anti-obesity agents, pregnancy |
| **Required Medical Information** | Hypertension (systolic blood pressure greater than 140mm Hg or diastolic blood pressure greater than 90mm Hg on more than one occasion), Dyslipidemia (LDL cholesterol greater than/= 160mg/dL: HDL cholesterol less than 35mg/dL: triglycerides greater than/= 400mg/dL), Type 2 Diabetes Mellitus, Coronary Heart Disease, or Obstructive Sleep Apnea |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 Year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of phentermine cap or phendimetrazine tab |
| **QL Criteria** | 1 capsule Per 1 Day |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# QUEtiapine Fumarate

**Products Affected**

- *quetiapine fumarate oral tablet 100 mg, 50 mg*

| | |
|---|---|
| **QL Criteria** | 3 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# QUEtiapine Fumarate

**Products Affected**

- *quetiapine fumarate oral tablet 200 mg*

| | |
|---|---|
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# QUEtiapine Fumarate

**Products Affected**

- *quetiapine fumarate oral tablet 25 mg*

| | |
|---|---|
| **QL Criteria** | 6 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# QUEtiapine Fumarate

**Products Affected**

- *quetiapine fumarate oral tablet 300 mg, 400 mg*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# QUEtiapine Fumarate ER

**Products Affected**

- *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg*

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# QUEtiapine Fumarate ER

**Products Affected**

- *quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg*

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Quillivant XR

**Products Affected**

- QUILLIVANT XR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Attention deficit hyperactivity disorder (ADHD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) |
| **Age Restrictions** | For Quillivant Only- 17 years of age and older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of an immediate release stimulant |
| **QL Criteria** | 1 bottle Per 1 fill |
| **Notes/ References** | Annual Review: 09/2017 |
| **Revision Date** | Prior Authorization: September 26, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RA TRUEtest Test

**Products Affected**

- RA TRUETEST TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RABEprazole Sodium

**Products Affected**

- *rabeprazole sodium*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma. |
| **Exclusion Criteria** | Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day |
| **Required Medical Information** | A diagnosis of Zollinger-Ellison syndrome, uncomplicated gastroesophageal reflux desease (GERD) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, short term court of high dose= 3 months |
| **Other Criteria** | |
| **ST Criteria** | ONCE DAILY DOSING OF RABEPRAZOLE (20mg), DEXILANT (60mg), AND NEXIUM (40mg): A documented contraindication, intolerance, allergy, or failure of Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. HIGH DOSE NEXIUM (80mg) OR HIGH DOSE RABEPRAZOLE (40mg): A documented contraindication, intolerance, allergy, or failure of 80mg/day of Prilosec OTC/omeprazole or pantoprazole or though 60mg/day of Prevacid 24H OTC. |
| **QL Criteria** | 1 tab Per 1 Day |

| | |
|---|---|
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ranexa

**Products Affected**

- RANEXA

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rasagiline Mesylate

**Products Affected**

- *rasagiline mesylate oral*

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ravicti

**Products Affected**

- RAVICTI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 20 bottles Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebetol

**Products Affected**

- REBETOL ORAL SOLUTION

| | |
|---|---|
| **QL Criteria** | 500 milliliters Per 1 prescription |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebif

**Products Affected**

- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 12 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebif Rebidose

**Products Affected**

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 12 syringes Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebif Rebidose Titration Pack

**Products Affected**

- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 titration pack Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rebif Titration Pack

**Products Affected**

- REBIF TITRATION PACK
  SUBCUTANEOUS SOLUTION
  PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 titration pack Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rectiv

**Products Affected**

- RECTIV

| | |
|---|---|
| **QL Criteria** | 30 grams Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: November 06, 2017 |

# RefuAH Plus Blood Glucose Test

**Products Affected**

- REFUAH PLUS BLOOD GLUCOSE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Relenza Diskhaler

**Products Affected**

- RELENZA DISKHALER

| | |
|---|---|
| **QL Criteria** | 20 inhalations Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Relistor

**Products Affected**

- RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure,Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concommitant use of opioid therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 0.6 ml Per 1 Day |
| **Notes/ References** | Annual Review: 10/2017 |
| **Revision Date** | Prior Authorization: April 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Relistor

**Products Affected**

- RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of opioid induced constipation due to non-cancer pain, OR a documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure,Alzheimer's disease/dementia, HIV/AIDS), receiving palliative care, and response to laxative therapy has not been sufficient and documented concommitant use of opioid therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 0.4 ml Per 1 Day |
| **Notes/ References** | Annual Review: 10/2017 |
| **Revision Date** | Prior Authorization: April 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Remicade

**Products Affected**

- REMICADE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Remicade.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Remodulin

**Products Affected**

- REMODULIN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Repaglinide-Metformin HCl

**Products Affected**

- *repaglinide-metformin hcl*

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Repatha

**Products Affected**

- REPATHA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 2 injections Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 10, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Repatha Pushtronex System

**Products Affected**

- REPATHA PUSHTRONEX SYSTEM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 1 syringe Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Repatha SureClick

**Products Affected**

- REPATHA SURECLICK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/PCSK9.html |
| **QL Criteria** | 2 injections Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 10, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rescula

**Products Affected**

- RESCULA

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of latanoprost |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Reveal Blood Glucose Test

**Products Affected**

- REVEAL BLOOD GLUCOSE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Revlimid

**Products Affected**

- REVLIMID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rexall Blood Glucose Test

**Products Affected**

- REXALL BLOOD GLUCOSE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rexulti

**Products Affected**

- REXULTI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Major Depressive Disorder (MDD), Schizophrenia |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of Major Depressive Disorder (MDD) or Schizophrenia |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | Annual Review: 08/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Reyataz

**Products Affected**

- REYATAZ ORAL CAPSULE 150 MG
- REYATAZ ORAL CAPSULE 300 MG

| | |
|---|---|
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Reyataz

**Products Affected**

- REYATAZ ORAL CAPSULE 200 MG

| | |
|---|---|
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rightest GS100 Blood Glucose

**Products Affected**

- RIGHTEST GS100 BLOOD GLUCOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rightest GS300 Blood Glucose

**Products Affected**

- RIGHTEST GS300 BLOOD GLUCOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rightest GS550 Blood Glucose

**Products Affected**

- RIGHTEST GS550 BLOOD GLUCOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Risedronate Sodium

**Products Affected**

- *risedronate sodium oral tablet 150 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg |
| **QL Criteria** | 1 tablet Per 28 Days |
| **Notes/ References** | Annual Review: 06/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Risedronate Sodium

**Products Affected**

- *risedronate sodium oral tablet 30 mg, 5 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Risedronate Sodium

**Products Affected**

- *risedronate sodium oral tablet 35 mg release*
- *risedronate sodium oral tablet delayed*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of alendronate weekly 70mg |
| **QL Criteria** | 4 tablets Per 28 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE

**Products Affected**

- *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *risperidone oral tablet dispersible 0.5 mg*
- *risperidone oral tablet dispersible 1 mg, 2 mg*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE

**Products Affected**

- *risperidone oral tablet 3 mg*
- *risperidone oral tablet dispersible 3 mg*

| | |
|---|---|
| **QL Criteria** | 3 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE

**Products Affected**

- *risperidone oral tablet 4 mg*
- *risperidone oral tablet dispersible 4 mg*

| | |
|---|---|
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE M-TAB

**Products Affected**

- *risperidone m-tab oral tablet dispersible 0.5 mg, 1 mg, 2 mg*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE M-TAB

**Products Affected**

- *risperidone m-tab oral tablet dispersible 3 mg*

| | |
|---|---|
| **QL Criteria** | 3 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# RisperiDONE M-TAB

**Products Affected**

- *risperidone m-tab oral tablet dispersible 4 mg*

| | |
|---|---|
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rituxan

**Products Affected**

- RITUXAN INTRAVENOUS SOLUTION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Rituxan.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Rituxan.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rizatriptan Benzoate

**Products Affected**

- *rizatriptan benzoate*

| | |
|---|---|
| **QL Criteria** | 9 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ROPINIRole HCl ER

**Products Affected**

- *ropinirole hcl er oral tablet extended release 24 hour 12 mg*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ROPINIRole HCl ER

**Products Affected**

- *ropinirole hcl er oral tablet extended release 24 hour 2 mg, 4 mg, 6 mg, 8 mg*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rosuvastatin Calcium

**Products Affected**

- *rosuvastatin calcium*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: atorvastatin, lovastatin, pravastatin, simvastain |
| **QL Criteria** | 1 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rozerem

**Products Affected**

- ROZEREM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Insomnia |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of insomnia |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of either zolpidem tartrate or zalelpon, and through zolpidem tartrate extended-release |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | Annual Review: 08/2017 |
| **Revision Date** | Prior Authorization: July 18, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Rubraca

**Products Affected**

- RUBRACA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Rubraca.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tablets Per 1 day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 09, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sabril

**Products Affected**

- SABRIL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 6 packs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Samsca

**Products Affected**

- SAMSCA ORAL TABLET 15 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/samsca.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Samsca

**Products Affected**

- SAMSCA ORAL TABLET 30 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/samsca.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sancuso

**Products Affected**

- SANCUSO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Chemotherapy induced nausea and vomiting |
| **Exclusion Criteria** | Cancer patients with non-chemotherapy related nausea and vomiting, patients with radiation-induced nausea and vomiting, patients with pregnancy-related nausea and vomiting, patients with post-operative nausea and vomiting |
| **Required Medical Information** | Patient is currently receiving chemotherapy and remains symptomatic despite treatment with oral antiemetics |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of oral ondansetron or oral granisetron |
| **QL Criteria** | 1 patch Per 1 fill |
| **Notes/ References** | Annual Review: 10/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Saphris

**Products Affected**

- SAPHRIS

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Savella

**Products Affected**

- SAVELLA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Fibromyalgia |
| **Exclusion Criteria** | |
| **Required Medical Information** | A diagnosis of fibromyalgia and documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SSRI, SNRI, gabapentin, or tramadol |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: May 10, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Savella Titration Pack

**Products Affected**

- SAVELLA TITRATION PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Fibromyalgia |
| **Exclusion Criteria** | |
| **Required Medical Information** | A diagnosis of fibromyalgia and documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of three drugs from three of the following drug/drug classes: tricyclic antidepressant, muscle relaxant, SSRI, SNRI, gabapentin, or tramadol |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: May 10, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Selzentry

**Products Affected**

- SELZENTRY ORAL SOLUTION

| | |
|---|---|
| **QL Criteria** | 8 bottles Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Selzentry

**Products Affected**

- SELZENTRY ORAL TABLET 150 MG

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Selzentry

**Products Affected**

- SELZENTRY ORAL TABLET 25 MG

| | |
|---|---|
| **QL Criteria** | 8 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Selzentry

**Products Affected**

- SELZENTRY ORAL TABLET 75 MG

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sensipar

**Products Affected**

- SENSIPAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Secondary Hyperparathyroidism (HPT) in adult patients with chronic kidney disease (CKD) on dialysis, Hypercalcemia in adult patients with Parathyroid Carcinoma, or Hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy. |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of one of Secondary Hyperparathyroidism (HPT) in an adult patient with chronic kidney disease (CKD) on dialysis,Hypercalcemia in an adult patient with parathyroid carcinoma (PC), or Hypercalcemia in an adult patient with primary hyperparathyroidism for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: July 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Serevent Diskus

**Products Affected**

- SEREVENT DISKUS

| | |
|---|---|
| **QL Criteria** | 1 box Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sertraline HCl

**Products Affected**

- *sertraline hcl oral tablet 100 mg*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sertraline HCl

**Products Affected**

- *sertraline hcl oral tablet 25 mg*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sertraline HCl

**Products Affected**

- *sertraline hcl oral tablet 50 mg*

| | |
|---|---|
| **QL Criteria** | 1.5 tag Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Signifor

**Products Affected**

- SIGNIFOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Signifor.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 2 amps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sildenafil Citrate

**Products Affected**

- *sildenafil citrate oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 3 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Simponi

**Products Affected**

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi.html |
| **QL Criteria** | 1 pen Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Simponi Aria

**Products Affected**

- SIMPONI ARIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Simponi_Aria.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 1 syringe Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Simulect

**Products Affected**

- SIMULECT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/Simulect.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Simvastatin

**Products Affected**

- *simvastatin oral*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sirturo

**Products Affected**

- SIRTURO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antimycobacterial_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 188 tabs Per 365 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sivextro

**Products Affected**

- SIVEXTRO ORAL

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of linezolid |
| **QL Criteria** | 6 tabs Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Smartest Blood Glucose Test

**Products Affected**

- SMARTEST BLOOD GLUCOSE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sodium Phenylbutyrate

**Products Affected**

- *sodium phenylbutyrate*
- *sodium phenylbutyrate oral powder 3 gm/tsp*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Solus V2 Test

**Products Affected**

- SOLUS V2 TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Somatuline Depot

**Products Affected**

- SOMATULINE DEPOT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Sandostatin.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Somavert

**Products Affected**

- SOMAVERT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/growthhormone.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sovaldi

**Products Affected**

- SOVALDI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Spiriva HandiHaler

**Products Affected**

- SPIRIVA HANDIHALER

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Incruse |
| **QL Criteria** | 1 capsule Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Spiriva Respimat

**Products Affected**

- SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Incruse |
| **QL Criteria** | 1 inhaler Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sporanox

**Products Affected**

- SPORANOX ORAL SOLUTION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Onychomycosis, invasive fungal infection, other fungal infection, superficial mycoses |
| **Exclusion Criteria** | Cosmetic use, patients with evidence of ventricular dysfunction such as CHF or a history of CHF. Coadministration with certain drugs metabolized by the cytochrome P-450 3A4 isoenzyme system (CYP3A4), cisapride, oral midazolam, pimozide, quinidine, dofetilide, triazolam, HMG-CoA reductase inhibitors metabolized by CYP3A4, such as lovastatin and simvastatin, and ergot alkaloids metabolized by CYP3A4, such as dihydroergotamine, ergotamine, ergonovine, and methylergonovine. |
| **Required Medical Information** | Itraconazole is covered for members who meet the following criteria: Invasive fungal infections in patients who are immunocompromised (such as histoplamosis, aspergillosis, and blastomycosis), treatment of tinea barbae, tinea capitis, tinea favosa, tinea corporis, tinea cruris, tinea faciei, tinea manuum, or tinea pedis, a diagnosis of majocchi granuloma, or a diagnosis of onychomycosis in diabetic patients or patients with peripheral vascular disease and either a positive onychomycosis susceptible pathogen culture or a positive PAS stain performed by a laboratory, or a diagnosis of onychomycosis with documented disabling pain or impairment and a positive onychomycosis susceptible pathogen culture |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Nail: 12 wk(toe),5 wk (finger) per year,Invasive: 1-3 mo based on severity, Other Dx: 1-6 wk |
| **Other Criteria** | |

| | |
|---|---|
| **ST Criteria** | FOR A DIAGNOSIS OF ONYCHOMYCOSIS, TINEA BARBAE, TIBNEA CAPITIS, TINEA FAVOSA: A documented contraindication, intolerance, allergy, or failure of terbinafine. FOR A DIAGNOSIS OF TINEA CORPORIS, TINEA CRURIS, TINEA FACIEI, TINEA MANUUM, TINEA PEDIS: A documented contraindication, intolerance, allergy, or failure of a topical antifungal and terbinafine. FOR A DIAGNOSIS OF TINEA VERSICOLOR: A documented contraindication, intolerance, allergy, or failure of selenium sulfide and a topcial antifungal. |
| **Notes/ References** | Annual Review: 09/2017 |
| **Revision Date** | Prior Authorization: August 25, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sprycel

**Products Affected**

- SPRYCEL ORAL TABLET 100 MG, 140 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sprycel

**Products Affected**

- SPRYCEL ORAL TABLET 20 MG, 50 MG, 70 MG, 80 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Stelara

**Products Affected**

- STELARA INTRAVENOUS PREFILLED SYRINGE
- STELARA SUBCUTANEOUS SOLUTION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Stelara.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Stimate

**Products Affected**

- STIMATE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/miscendocrine.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Stiolto Respimat

**Products Affected**

- STIOLTO RESPIMAT

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Anoro Ellipta |
| **QL Criteria** | 1 inhaler Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Stivarga

**Products Affected**

- STIVARGA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Striant

**Products Affected**

- STRIANT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes |
| **Required Medical Information** | Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only, or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 2 buccals Per 1 Day |
| **Notes/ References** | Annual Review: 02/2017 |

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| | |
|---|---|
| **Revision Date** | Prior Authorization: February 08, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Stribild

**Products Affected**

- STRIBILD

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviral_hiv.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Striverdi Respimat

**Products Affected**

- STRIVERDI RESPIMAT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Chronic Obstructive Pulmonary Disorder (COPD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | Documented diagnosis of Chronic obstructive pulmonary disease (COPD |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Serevent |
| **QL Criteria** | 1 inhaler Per 30 Days |
| **Notes/ References** | Annual Review: 07/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Suboxone

**Products Affected**

- SUBOXONE SUBLINGUAL FILM

| | |
|---|---|
| **QL Criteria** | 2 films Per 1 Day |
| **Notes/ References** | Annual Review: 04/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SulfaSALAzine

**Products Affected**

- *sulfasalazine oral*

| | |
|---|---|
| **QL Criteria** | 8 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sulfazine

**Products Affected**

- *sulfazine*

| | |
|---|---|
| **QL Criteria** | 8 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SUMAtriptan

**Products Affected**

- *sumatriptan nasal*

| | |
|---|---|
| **QL Criteria** | 6 sprays Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SUMAtriptan Succinate

**Products Affected**

- *sumatriptan succinate oral*

| | |
|---|---|
| **QL Criteria** | 9 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SUMAtriptan Succinate

**Products Affected**

- *sumatriptan succinate subcutaneous solution 6 mg/0.5ml*

| | |
|---|---|
| **QL Criteria** | 10 vials Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SUMAtriptan Succinate

**Products Affected**

- *sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml*

| | |
|---|---|
| **QL Criteria** | 2 boxes Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SUMAtriptan Succinate Refill

**Products Affected**

- *sumatriptan succinate refill subcutaneous solution cartridge*

| | |
|---|---|
| **QL Criteria** | 2 boxes Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Supprelin LA

**Products Affected**

- SUPPRELIN LA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: February 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sure Edge Test

**Products Affected**

- SURE EDGE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SureChek Blood Glucose Test

**Products Affected**

- SURECHEK BLOOD GLUCOSE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SureStep Pro Linearity

**Products Affected**

- SURESTEP PRO LINEARITY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sure-Test EasyPlus Mini Test

**Products Affected**

- SURE-TEST EASYPLUS MINI TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sutent

**Products Affected**

- SUTENT ORAL CAPSULE 12.5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sutent

**Products Affected**

- SUTENT ORAL CAPSULE 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sutent

**Products Affected**

- SUTENT ORAL CAPSULE 37.5 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Sylatron

**Products Affected**

- SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Symbicort

**Products Affected**

- SYMBICORT

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Dulera |
| **QL Criteria** | 1 inhaler Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# SymlinPen 120

**Products Affected**

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA Approved uses |
| **Exclusion Criteria** | Poor compliance with current insulin regimen, Poor compliance with prescribed self-blood glucose monitorings, An A1C greater than 9%, Recurrent severe hypoglycemia requiring assistance during the previous 6 months, Presence of hypoglycemia unawareness, Confirmed diagnosis of gastroparesis, Need for medications that stimulate GI motility , Patient is less than 18 years old, Concurrent use with other oral antidiabetic medications (except metformin and sulfonylureas) or drugs that alter gastrointestinal motility |
| **Required Medical Information** | A documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin). For extended renewals: a documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin), and the patient demonstrated an expected reduction in HbA1c since starting this therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | initial: 6 months - extended: 12 months |
| **Other Criteria** | |
| **QL Criteria** | 4 pens Per 1 month |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: June 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

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# SymlinPen 60

**Products Affected**

- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA Approved uses |
| **Exclusion Criteria** | Poor compliance with current insulin regimen, Poor compliance with prescribed self-blood glucose monitorings, An A1C greater than 9%, Recurrent severe hypoglycemia requiring assistance during the previous 6 months, Presence of hypoglycemia unawareness, Confirmed diagnosis of gastroparesis, Need for medications that stimulate GI motility , Patient is less than 18 years old, Concurrent use with other oral antidiabetic medications (except metformin and sulfonylureas) or drugs that alter gastrointestinal motility |
| **Required Medical Information** | A documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin). For extended renewals: a documented diagnosis of type 1 or type 2 diabetes mellitus and the patient concurrently using rapid or short-acting insulin (e.g., Humalog or regular insulin), and the patient demonstrated an expected reduction in HbA1c since starting this therapy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | initial: 6 months - extended: 12 months |
| **Other Criteria** | |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: June 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synagis

**Products Affected**

- SYNAGIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Synagis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synarel

**Products Affected**

- SYNAREL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: February 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synjardy

**Products Affected**

- SYNJARDY

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synjardy XR

**Products Affected**

- SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synjardy XR

**Products Affected**

- SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Synribo

**Products Affected**

- SYNRIBO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Syprine

**Products Affected**

- SYPRINE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Taclonex

**Products Affected**

- TACLONEX EXTERNAL SUSPENSION

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of calcipotriene and a medium to high potency topical steroid |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tacrolimus

**Products Affected**

- *tacrolimus external*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 2 weeks (14 days) of one preferred alternative topical corticosteroid (triamcinolone acetonide, fluocinonide cream, augmented betamethasone gel, betamethasone dipropionate, or fluticasone propionate ointment) |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tafinlar

**Products Affected**

- TAFINLAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tamiflu

**Products Affected**

- TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML

| | |
|---|---|
| **QL Criteria** | 3 bottles Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tanzeum

**Products Affected**

- TANZEUM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type 2 Diabetes Mellitus (NIDDM) |
| **Exclusion Criteria** | Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis |
| **Required Medical Information** | Patient must have an A1C level is greater than 6.5%, |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR |
| **QL Criteria** | 4 pens Per 1 month |
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tarceva

**Products Affected**

- TARCEVA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Targretin

**Products Affected**

- TARGRETIN EXTERNAL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Targretin.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tasigna

**Products Affected**

- TASIGNA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 4 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tazarotene

**Products Affected**

- *tazarotene external*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of tretinoin |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tazorac

**Products Affected**

- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of tretinoin |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Taztia XT

**Products Affected**

- *taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg, 360 mg*

| | |
|---|---|
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Taztia XT

**Products Affected**

- *taztia xt oral capsule extended release 24 hour 240 mg*

| | |
|---|---|
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tecfidera

**Products Affected**

- TECFIDERA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/multiple_sclerosis.html |
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Technivie

**Products Affected**

- TECHNIVIE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tekturna

**Products Affected**

- TEKTURNA

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tekturna HCT

**Products Affected**

- TEKTURNA HCT

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Telcare Blood Glucose Test

**Products Affected**

- TELCARE BLOOD GLUCOSE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Telmisartan

**Products Affected**

- *telmisartan*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Telmisartan-Amlodipine

**Products Affected**

- *telmisartan-amlodipine*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Telmisartan-HCTZ

**Products Affected**

- *telmisartan-hctz*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Temazepam

**Products Affected**

- *temazepam oral capsule 22.5 mg, 7.5 mg*

| | |
|---|---|
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Temozolomide

**Products Affected**

- *temozolomide*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Testopel

**Products Affected**

- TESTOPEL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes |
| **Required Medical Information** | Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only, or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **Notes/ References** | |

| | |
|---|---|
| **Revision Date** | Prior Authorization: February 08, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Testosterone

**Products Affected**

- *testosterone transdermal gel 10 mg/act (2%)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes |
| **Required Medical Information** | Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only, or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 60 grams Per 1 fill |
| **Notes/ References** | Annual Review: 02/2017 |

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| | |
|---|---|
| **Revision Date** | Prior Authorization: February 08, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Testosterone

**Products Affected**

- *testosterone transdermal gel 12.5 mg/act (1%)*
- *testosterone transdermal gel 50 mg/5gm (1%)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes |
| **Required Medical Information** | Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only, or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 10 grams Per 1 Day |
| **Notes/ References** | Annual Review: 02/2017 |

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| | |
|---|---|
| **Revision Date** | Prior Authorization: February 08, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Testosterone

**Products Affected**

- *testosterone transdermal gel 25 mg/2.5gm (1%)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes |
| **Required Medical Information** | Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only, or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 2.5 grams Per 1 Day |
| **Notes/ References** | |

2017 Aetna Pharmacy Drug List - Individual
Last Update 12/2017

| | |
|---|---|
| **Revision Date** | Prior Authorization: February 08, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Testosterone

**Products Affected**

- *testosterone transdermal solution*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Primary hypogonadism or hypogonadotropic hypogonadism, gender dysphoria, gender reassignment |
| **Exclusion Criteria** | Patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes |
| **Required Medical Information** | Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only, or (3) Member has a documented diagnosis of gender dysphoria or documentation of undergoing gender reassignment surgery. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 6 milliliters Per 1 Day |
| **Notes/ References** | |

2017 Aetna Pharmacy Drug List - Individual
Last Update 12/2017

| | |
|---|---|
| **Revision Date** | Prior Authorization: February 08, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tetrabenazine

**Products Affected**

- *tetrabenazine oral tablet 12.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 8 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: May 31, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tetrabenazine

**Products Affected**

- *tetrabenazine oral tablet 25 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/xenazine.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: May 31, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TGT Blood Glucose Test

**Products Affected**

- *tgt blood glucose test*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Thalomid

**Products Affected**

- THALOMID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Thiola

**Products Affected**

- THIOLA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TiaGABine HCl

**Products Affected**

- *tiagabine hcl oral tablet 2 mg*

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TiaGABine HCl

**Products Affected**

- *tiagabine hcl oral tablet 4 mg*

| | |
|---|---|
| **QL Criteria** | 4 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tivicay

**Products Affected**

- TIVICAY

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tivicay

**Products Affected**

- TIVICAY

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tobramycin

**Products Affected**

- *tobramycin inhalation*

| | |
|---|---|
| **QL Criteria** | 56 vials Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tolterodine Tartrate

**Products Affected**

- *tolterodine tartrate*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tolterodine Tartrate ER

**Products Affected**

- *tolterodine tartrate er*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR |
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Topiramate

**Products Affected**

- *topiramate oral capsule sprinkle*

| | |
|---|---|
| **QL Criteria** | 4 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Toviaz

**Products Affected**

- TOVIAZ

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR and through either Vesicare or Myrbetriq |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tracleer

**Products Affected**

- TRACLEER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tradjenta

**Products Affected**

- TRADJENTA

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | Annual Review: 05/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TraMADol HCl

**Products Affected**

- *tramadol hcl oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TraMADol HCl ER

**Products Affected**

- *tramadol hcl er oral tablet extended release 24 hour*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of tramadol |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TraMADol HCl ER (Biphasic)

**Products Affected**

- *tramadol hcl er (biphasic)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of tramadol |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tramadol-Acetaminophen

**Products Affected**

- *tramadol-acetaminophen*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tranexamic Acid

**Products Affected**

- *tranexamic acid oral*

| | |
|---|---|
| **QL Criteria** | 30 tablet Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trelstar Mixject

**Products Affected**

- TRELSTAR MIXJECT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: February 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tresiba FlexTouch

**Products Affected**

- TRESIBA FLEXTOUCH

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Levemir |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Triamcinolone Acetonide

**Products Affected**

- *triamcinolone acetonide nasal aerosol*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide |
| **QL Criteria** | 1 bottle Per 1 month |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trintellix

**Products Affected**

- TRINTELLIX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Major Depressive Disorder (MDD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | A diagnosis of Major Depressive Disorder |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.) |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: April 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Triptodur

**Products Affected**

- TRIPTODUR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/Gonadotropins.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: February 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Triumeq

**Products Affected**

- TRIUMEQ

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trospium Chloride

**Products Affected**

- *trospium chloride*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trospium Chloride ER

**Products Affected**

- *trospium chloride er*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR |
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TRUEtest Test

**Products Affected**

- TRUETEST TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TrueTrack Test

**Products Affected**

- TRUETRACK TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Trulicity

**Products Affected**

- TRULICITY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type 2 Diabetes Mellitus (NIDDM) |
| **Exclusion Criteria** | Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis |
| **Required Medical Information** | Patient must have an A1C level is greater than 6.5%, |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR |
| **QL Criteria** | 4 injections Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Truvada

**Products Affected**

- TRUVADA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviral_hiv.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tudorza Pressair

**Products Affected**

- TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of Incruse |
| **QL Criteria** | 1 inhaler Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# TussiCaps

**Products Affected**

- TUSSICAPS

| | |
|---|---|
| **QL Criteria** | 20 caps Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tybost

**Products Affected**

- TYBOST

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Tykerb

**Products Affected**

- TYKERB

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Uceris

**Products Affected**

- UCERIS ORAL

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ulesfia

**Products Affected**

- ULESFIA

| | |
|---|---|
| **QL Criteria** | 3 bottles Per 1 fill |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Uloric

**Products Affected**

- ULORIC

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of allopurinol |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ultima Test

**Products Affected**

- ULTIMA TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# UltraTRAK PRO Test

**Products Affected**

- ULTRATRAK PRO TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# UltraTRAK Ultimate Test

**Products Affected**

- ULTRATRAK ULTIMATE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Valcyte

**Products Affected**

- VALCYTE ORAL SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopical.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ValGANciclovir HCl

**Products Affected**

- *valganciclovir hcl oral solution reconstituted*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopical.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ValGANciclovir HCl

**Products Affected**

- *valganciclovir hcl oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ID/antiviraltopical.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 102 tablets Per 30 30s |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Valsartan

**Products Affected**

- *valsartan*

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Valsartan-Hydrochlorothiazide

**Products Affected**

- *valsartan-hydrochlorothiazide*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vectibix

**Products Affected**

- VECTIBIX INTRAVENOUS SOLUTION
  100 MG/5ML, 400 MG/20ML

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Vectibix.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Velcade

**Products Affected**

- VELCADE INJECTION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Velcade.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venlafaxine HCl

**Products Affected**

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

| | |
|---|---|
| **QL Criteria** | 3 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venlafaxine HCl

**Products Affected**

- *venlafaxine hcl oral tablet 37.5 mg*

| | |
|---|---|
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venlafaxine HCl

**Products Affected**

- *venlafaxine hcl oral tablet 50 mg*

| | |
|---|---|
| **QL Criteria** | 6 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venlafaxine HCl

**Products Affected**

- *venlafaxine hcl oral tablet 75 mg*

| | |
|---|---|
| **QL Criteria** | 5 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venlafaxine HCl ER

**Products Affected**

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

| | |
|---|---|
| **QL Criteria** | 2 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Venlafaxine HCl ER

**Products Affected**

- *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg*

| | |
|---|---|
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ventavis

**Products Affected**

- VENTAVIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CV/pulmonaryhypertensionagents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: December 22, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Verapamil HCl ER

**Products Affected**

- *verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg*

| | |
|---|---|
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Verapamil HCl ER

**Products Affected**

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

| | |
|---|---|
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# VESIcare

**Products Affected**

- VESICARE

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of oxybutynin or trospium IR |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vicodin

**Products Affected**

- *vicodin oral tablet 5-300 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vicodin ES

**Products Affected**

- *vicodin es oral tablet 7.5-300 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vicodin HP

**Products Affected**

- *vicodin hp oral tablet 10-300 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 120 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Victory AGM-4000 Test

**Products Affected**

- VICTORY AGM-4000 TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Victoza

**Products Affected**

- VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type 2 Diabetes Mellitus (NIDDM) |
| **Exclusion Criteria** | Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis |
| **Required Medical Information** | Patient must have an A1C level is greater than 6.5%, |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: Invokana/Invokamet, Jentadueto/Tradjenta, or Januvia/Janumet/Janumet XR |
| **QL Criteria** | 9 ML Per 1 month |
| **Notes/ References** | Annual Review: 02/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viekira Pak

**Products Affected**

- VIEKIRA PAK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viekira XR

**Products Affected**

- VIEKIRA XR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **QL Criteria** | 3 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vigabatrin

**Products Affected**

- *vigabatrin*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/anticonvulsants.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 6 packets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viibryd

**Products Affected**

- VIIBRYD ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Major Depressive Disorder (MDD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | A diagnosis of Major Depressive Disorder |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.) |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: April 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viibryd Starter Pack

**Products Affected**

- VIIBRYD STARTER PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Major Depressive Disorder (MDD) |
| **Exclusion Criteria** | |
| **Required Medical Information** | A diagnosis of Major Depressive Disorder |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of three different antidepressants from at least two different therapeutic subclasses (includes SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs) (step therapy not required if patient is a new member and has been receiving medication therapy for more than 4 weeks.) |
| **Notes/ References** | Annual Review: 05/2017 |
| **Revision Date** | Prior Authorization: April 20, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vimpat

**Products Affected**

- VIMPAT ORAL TABLET

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viokace

**Products Affected**

- VIOKACE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Exocrine pancreatic Insufficiency |
| **Exclusion Criteria** | Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use). |
| **Required Medical Information** | Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of 2 weeks of Zenpep |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Viread

**Products Affected**

- VIREAD ORAL TABLET

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vocal Point Blood Glucose Test

**Products Affected**

- VOCAL POINT BLOOD GLUCOSE TEST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 30 Days |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Voriconazole

**Products Affected**

- *voriconazole oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Fungal infections |
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of invasive aspergillosis or with a serious systemic fungal infection caused by Scedosporium apiospermum and Fusarium spp., for the treatment of esophageal candidiasis that is resistant to treatment with fluconazole and itraconazole, or for the treatment of candidemia in non-neutropenic patients and the following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds that are unresponsive to treatment with fluconazole (Continue therapy for 14 days after the patient is afebrile and blood cultures are negative). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Invasive aspergillosis: 12 weeks, Oral Candidiasis: 3 weeks MAX, Candidemia: 12 weeks |
| **Other Criteria** | |
| **Notes/ References** | Annual Review: 09/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vosevi

**Products Affected**

- VOSEVI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Votrient

**Products Affected**

- VOTRIENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vpriv

**Products Affected**

- VPRIV

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vraylar

**Products Affected**

- VRAYLAR ORAL CAPSULE 1.5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Bipolar disorder or schizophrenia |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 4 capsule Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vraylar

**Products Affected**

- VRAYLAR ORAL CAPSULE 3 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Bipolar disorder or schizophrenia |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 2 capsule Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vraylar

**Products Affected**

- VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Bipolar disorder or schizophrenia |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **QL Criteria** | 1 capsule Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vraylar

**Products Affected**

- VRAYLAR ORAL CAPSULE THERAPY PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Bipolar disorder or schizophrenia |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: aripiprazole, risperidone, quetiapine, ziprasidone, olanzapine, or clozapine |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vyvanse

**Products Affected**

- VYVANSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Attention deficit hyperactivity disorder (ADHD), Binge Eating Disorder |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) or Binge Eating Disorder |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER |
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: November 14, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Vyvanse

**Products Affected**

- VYVANSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Attention deficit hyperactivity disorder (ADHD), Binge Eating Disorder |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of Attention deficit hyperactivity disorder (ADHD) or Binge Eating Disorder |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: November 14, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# WaveSense Presto

**Products Affected**

- WAVESENSE PRESTO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Type II Diabetes Mellitus |
| **Exclusion Criteria** | |
| **Required Medical Information** | There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year, limit one meter per year |
| **Other Criteria** | |
| **QL Criteria** | 300 strips Per 1 month |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 60

**Products Affected**

- WIDE-SEAL DIAPHRAGM 60

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 65

**Products Affected**

- WIDE-SEAL DIAPHRAGM 65

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 70

**Products Affected**

- WIDE-SEAL DIAPHRAGM 70

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 75

**Products Affected**

- WIDE-SEAL DIAPHRAGM 75

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 80

**Products Affected**

- WIDE-SEAL DIAPHRAGM 80

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 85

**Products Affected**

- WIDE-SEAL DIAPHRAGM 85

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 90

**Products Affected**

- WIDE-SEAL DIAPHRAGM 90

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Wide-Seal Diaphragm 95

**Products Affected**

- WIDE-SEAL DIAPHRAGM 95

| | |
|---|---|
| **QL Criteria** | 1 diaphram Per 1 year |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xalkori

**Products Affected**

- XALKORI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xatmep

**Products Affected**

- XATMEP

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Treatment of acute lymphoblastic leukemia (ALL) or polyarticular juvenile idiopathic arthritis (pJIA) in pediatric patients |
| **Exclusion Criteria** | |
| **Required Medical Information** | A documented diagnosis of Acute Lymphoblastic Leukemia (ALL) in a pediatric patient (18 years and younger) as part of a multi-phase, combination chemotherapy maintenance regimen or a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA) in pediatric patients (18 years and younger) who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs). Regardless of diagnosis, the patient must have a documented inability to swallow tablets/capsules. |
| **Age Restrictions** | Approved for those 18 years of age or younger |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: July 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xeljanz

**Products Affected**

- XELJANZ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xeljanz XR

**Products Affected**

- XELJANZ XR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/Xeljanz_XeljanzXR.html |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xeomin

**Products Affected**

- XEOMIN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/botulinum_toxin.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xgeva

**Products Affected**

- XGEVA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xiaflex

**Products Affected**

- XIAFLEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/duputrens_contracture_treatments.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xifaxan

**Products Affected**

- XIFAXAN ORAL TABLET 200 MG

| | |
|---|---|
| **QL Criteria** | 9 tabs Per 1 fill |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xifaxan

**Products Affected**

- XIFAXAN ORAL TABLET 550 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea. |
| **Exclusion Criteria** | Pregnancy, Severe hepatic impairment (child-Pugh C) |
| **Required Medical Information** | FOR HEPATIC ENCHEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy. |
| **Age Restrictions** | 18 years or older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days. |
| **Other Criteria** | |
| **ST Criteria** | FOR HEPATIC ENCEPHALOPATHY: A documented contraindication, intolerance, allergy, or failure of lactulose solution |
| **QL Criteria** | 3 tablets Per 1 Day |
| **Notes/ References** | Annual Review: 04/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xigduo XR

**Products Affected**

- XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG

| | |
|---|---|
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xigduo XR

**Products Affected**

- XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG

| | |
|---|---|
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xtampza ER

**Products Affected**

- XTAMPZA ER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xtandi

**Products Affected**

- XTANDI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **QL Criteria** | 4 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xuriden

**Products Affected**

- XURIDEN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/metabolic_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 packets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xylon

**Products Affected**

- XYLON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Xyrem

**Products Affected**

- XYREM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/CNS/cataplexy-xyrem.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Yervoy

**Products Affected**

- YERVOY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/yervoy.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zaleplon

**Products Affected**

- *zaleplon*

| | |
|---|---|
| **QL Criteria** | 1 capsule Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zamicet

**Products Affected**

- ZAMICET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA approved indications |
| **Exclusion Criteria** | |
| **Required Medical Information** | (1) A MEMBER WILL RECEIVE LIFETIME APPROVAL OF THE REQUESTED MEDICATION WHEN: Member is in hospice care, if terminally ill or has end-of-life care (other than hospice), or has an active oncology diagnosis (pain medication being used for pain for cancer patients) or palliative care. (2) FOR A DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE ACUTE PAIN (INCLUDING POST-SURGICAL PAIN), TRAUMATIC INJURY, OR FOR A CHILD ON AN OPIOID WEAN AT TIME OF HOSPITAL DISCHARGE: additional medication after initial coverage will be approved for up to 1 month. (3) FOR A DOCUMENTED DIAGNOSIS OF CHRONIC PAIN: which includes conditions of chronic pain not mentioned above, the prescriber must certify there is an active treatment plan that includes but is not limited to a specific treatment objective, the use of other pharmacological and non-pharmacological agents for pain relief as appropriate, that there has been an informed consent document signed and an addiction risk assessment performed, and that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists. When these criteria are met, the medication will be approved for an initial 3 months. Continuation requests may be approved for up to an additional 6 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Length of Therapy; see required medical information |
| **Other Criteria** | |

| | |
|---|---|
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 06, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zarxio

**Products Affected**

- ZARXIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MISC/G-CSF.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zavesca

**Products Affected**

- ZAVESCA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: ?http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **ST Criteria** | http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/gaucher_disease.html |
| **QL Criteria** | 3 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: January 11, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zegerid OTC

**Products Affected**

- ZEGERID OTC

| | |
|---|---|
| **QL Criteria** | 1 cap Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zelapar

**Products Affected**

- ZELAPAR

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of selegiline |
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zelboraf

**Products Affected**

- ZELBORAF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 8 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zemaira

**Products Affected**

- ZEMAIRA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ENDO/Alpha-1 Antitrypsin Inhibitor Therapy.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zenatane

**Products Affected**

- ZENATANE

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of minocycline or doxycycline |
| **QL Criteria** | 2 capsules Per 1 Day |
| **Notes/ References** | Annual Review: 02/2016 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zepatier

**Products Affected**

- ZEPATIER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/GI/hepatitis_c.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 1 tablet Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zetonna

**Products Affected**

- ZETONNA

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of fluticasone propionate and flunisolide |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ziana

**Products Affected**

- ZIANA

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of tretinoin |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zioptan

**Products Affected**

- ZIOPTAN

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of latanoprost |
| **Notes/ References** | Annual Review: 03/2017 |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Ziprasidone HCl

**Products Affected**

- *ziprasidone hcl*

| | |
|---|---|
| **QL Criteria** | 2 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zoledronic Acid

**Products Affected**

- *zoledronic acid intravenous concentrate*
- *zoledronic acid intravenous solution*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/MUSC/bone_disease_agents.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zolinza

**Products Affected**

- ZOLINZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 caps Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ZOLMitriptan

**Products Affected**

- *zolmitriptan oral tablet*
- *zolmitriptan oral tablet dispersible 2.5 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan |
| **QL Criteria** | 6 tablets Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# ZOLMitriptan

**Products Affected**

- *zolmitriptan oral tablet dispersible 5 mg*

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following: sumatriptan, naratriptan, rizatriptan |
| **QL Criteria** | 30 tablet Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zolpidem Tartrate

**Products Affected**

- *zolpidem tartrate oral*

| | |
|---|---|
| **QL Criteria** | 2 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zolpidem Tartrate ER

**Products Affected**

- *zolpidem tartrate er*

| | |
|---|---|
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zomig

**Products Affected**

- ZOMIG NASAL SOLUTION 5 MG

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of two of the following:  sumatriptan, naratriptan, rizatriptan |
| **QL Criteria** | 6 sprays Per 30 fills |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zonalon

**Products Affected**

- ZONALON

| | |
|---|---|
| **QL Criteria** | 45 grams Per 30 Days |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zontivity

**Products Affected**

- ZONTIVITY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Reduction of the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD) |
| **Exclusion Criteria** | Do not use in patients with history of stroke, history of transient ischemic attack (TIA), or history of intracranial hemorrhage (ICH), or active pathological bleeding |
| **Required Medical Information** | Documented diagnosis or history of myocardial infarction (MI) or peripheral arterial disease (PAD) and concurrent use of aspirin or clopidogrel |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | |
| **QL Criteria** | 1 tab Per 1 Day |
| **Notes/ References** | Annual Review: 06/2017 |
| **Revision Date** | Prior Authorization: July 19, 2017<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zovirax

**Products Affected**

- ZOVIRAX EXTERNAL CREAM

| | |
|---|---|
| **ST Criteria** | A documented contraindication, intolerance, allergy, or failure of oral acyclovir |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: August 25, 2015<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zydelig

**Products Affected**

- ZYDELIG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zykadia

**Products Affected**

- ZYKADIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zytiga

**Products Affected**

- ZYTIGA ORAL TABLET 250 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 4 tabs Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

# Zytiga

**Products Affected**

- ZYTIGA ORAL TABLET 500 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2017/ANEOPL/Antineoplastics.html |
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Refer to the clinical policy bulletin above for details. |
| **Other Criteria** | |
| **QL Criteria** | 2 tablets Per 1 Day |
| **Notes/ References** | |
| **Revision Date** | Prior Authorization: September 21, 2016<br>Step Therapy: August 25, 2015<br>Quantity Limits: August 25, 2015 |

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