Abilify

Products Affected

- ABILIFY ORAL SOLUTION

ST Criteria	Trial of one month of ABILIFY TABLET
QL Criteria	30 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Abilify

Products Affected

- ABILIFY ORAL TABLET

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Abilify Discmelt

Products Affected

- ABILIFY DISCMELT

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

Abilify Maintena

Products Affected

- ABILIFY MAINTENA

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

Absorica

Products Affected

- ABSORICA

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring ANDMember is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria:1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has received a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
ST Criteria	Trial of 1 generic oral antibiotic prescribed for the treatment of acne (i.e., minocycline or doxycycline)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Abstral

Products Affected

- ABSTRAL

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one week each of the preferred generic alternative, fentanyl transmucosal lozenge AND two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	15 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acanya

Products Affected

- ACANYA

ST Criteria	Trial of one month of the preferred generic alternative, benzoyl peroxide/clindamycin phosphate gel OR benzoyl peroxide/erythromycin gel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aciphex

Products Affected

- ACIPHEX

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AcipHex Sprinkle

Products Affected

- ACIPHEX SPRINKLE

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acticlate

Products Affected

- ACTICLATE

PA Criteria	Criteria Details
Covered Uses	For Acticlate Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age), AND: A documented diagnosis of acne or rosacea or another infection for which a tetracycline-class antimicrobial is indicated
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 YEAR
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
ST Criteria	Trial of one month of doxycycline
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actiq

Products Affected

- ACTIQ BUCCAL LOLLIPOP 800 MCG, 1600 MCG, 600 MCG, 1200 MCG, 400 MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one week each of the preferred generic alternative, fentanyl transmucosal lozenge AND two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	15 lollipops Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Activella

Products Affected

- ACTIVELLA

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

Actonel

Products Affected

- ACTONEL ORAL TABLET 5 MG, 30 MG

ST Criteria	Trial of 1 month of alendronate weekly.
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actonel

Products Affected

- ACTONEL ORAL TABLET 150 MG

ST Criteria	Trial of 1 month of alendronate weekly.
QL Criteria	1 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actonel

Products Affected

- ACTONEL ORAL TABLET 35 MG

ST Criteria	Trial of 1 month of alendronate weekly.
QL Criteria	1 tab Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actoplus Met

Products Affected

- ACTOPLUS MET

ST Criteria	Trial of one month of pioglitazone/metformin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actoplus met XR

Products Affected

- ACTOPLUS MET XR

ST Criteria	Trial of one month of pioglitazone/metformin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actos

Products Affected

- ACTOS

ST Criteria	Trial of one month of pioglitazone
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acular

Products Affected

- ACULAR

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

Acular LS

Products Affected

- ACULAR LS

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

Acuvail

Products Affected

- ACUVAIL

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

Adcirca

Products Affected

- ADCIRCA

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

Adderall

Products Affected

- ADDERALL ORAL TABLET 12.5 MG, 5 MG, 15 MG, 7.5 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adderall

Products Affected

- ADDERALL ORAL TABLET 30 MG, 10 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adderall

Products Affected

- ADDERALL ORAL TABLET 20 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	3 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adderall XR

Products Affected

- ADDERALL XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adempas

Products Affected

- ADEMPAS

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

Adoxa

Products Affected

- ADOXA

PA Criteria	Criteria Details
Covered Uses	For Adoxa, Dynacin, Minocin and Monodox Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age) AND ONE of the following: 1) A documented diagnosis of acne or rosacea, OR: 2) A documented diagnosis of infection other than acne or rosacea
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
ST Criteria	Trial of three days of: doxycycline (for Acticlate, Adoxa, Oraxyl or Monodox) or minocycline (for Dynacin or Minocin)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adoxa Pak 1/100

Products Affected

- ADOXA PAK 1/100

PA Criteria	Criteria Details
Covered Uses	For Adoxa, Dynacin, Minocin and Monodox Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age) AND ONE of the following: 1) A documented diagnosis of acne or rosacea, OR: 2) A documented diagnosis of infection other than acne or rosacea
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
ST Criteria	Trial of three days of: doxycycline (for Acticlate, Adoxa, Oraxyl or Monodox) or minocycline (for Dynacin or Minocin)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adoxa Pak 1/150

Products Affected

- ADOXA PAK 1/150

PA Criteria	Criteria Details
Covered Uses	For Adoxa, Dynacin, Minocin and Monodox Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age) AND ONE of the following: 1) A documented diagnosis of acne or rosacea, OR: 2) A documented diagnosis of infection other than acne or rosacea
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
ST Criteria	Trial of three days of: doxycycline (for Acticlate, Adoxa, Oraxyl or Monodox) or minocycline (for Dynacin or Minocin)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adoxa Pak 2/100

Products Affected

- ADOXA PAK 2/100

PA Criteria	Criteria Details
Covered Uses	For Adoxa, Dynacin, Minocin and Monodox Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age) AND ONE of the following: 1) A documented diagnosis of acne or rosacea, OR: 2) A documented diagnosis of infection other than acne or rosacea
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
ST Criteria	Trial of three days of: doxycycline (for Acticlate, Adoxa, Oraxyl or Monodox) or minocycline (for Dynacin or Minocin)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adrenaclick

Products Affected

- ADRENACLICK

PA Criteria	Criteria Details
Covered Uses	emergency treatment of severe allergic reactions including anaphylaxis
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 prior use of Auvi-Q
QL Criteria	2 doses Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advair Diskus

Products Affected

- ADVAIR DISKUS

PA Criteria	Criteria Details
Covered Uses	asthma, in patients aged 12 years and older OR COPD Advair diskus 100/50 in Patients age 4-11 with Asthma - No PA required.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA members are 12 and older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Asthma: Trial of 1 month of Symbicort AND Dulera COPD: Trial of 1 month of Symbicort AND Spiriva
QL Criteria	1 disk Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advair HFA

Products Affected

- ADVAIR HFA

PA Criteria	Criteria Details
Covered Uses	asthma in patients aged 12 years and older
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month of Symbicort or Dulera
QL Criteria	1 inhaler Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advicor

Products Affected

- ADVICOR

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

Aerospan

Products Affected

- AEROSPAN

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Medical Exception for Flovent Diskus, Flovent HFA, and Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Trial of 1 month of Asmanex AND Qvar
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Afinitor

Products Affected

- AFINITOR

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

Afinitor Disperz

Products Affected

- AFINITOR DISPERZ

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

Afrezza

Products Affected

- AFREZZA

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of one month of one rapid-acting insulin (Humulin OR Humalog)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Akynzeo

Products Affected

- AKYNZEO

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

Aldara

Products Affected

- ALDARA

QL Criteria	120 max day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alendronate Sodium

Products Affected

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

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

Alendronate Sodium

Products Affected

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

QL Criteria	1 tab Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alfuzosin HCl ER

Products Affected

- *alfuzosin hcl er*

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Almotriptan Malate

Products Affected

- *almotriptan malate*

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

Alora

Products Affected

- ALORA TRANSDERMAL PATCH BIWEEKLY 0.025 MG/24HR

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

Alora

Products Affected

- ALORA TRANSDERMAL PATCH BIWEEKLY 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR

QL Criteria	8 patch Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

Altavera

Products Affected

- ALTAVERA

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

Altoprev

Products Affected

- ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR* 40 MG

ST Criteria	Trial of 1 month of generic lovastatin and Crestor
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Altoprev

Products Affected

- ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR* 20 MG, 60 MG

ST Criteria	Trial of 1 month of generic lovastatin and Crestor
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alvesco

Products Affected

- ALVESCO

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Medical Exception for Flovent Diskus, Flovent HFA, and Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Trial of 1 month of Asmanex AND Qvar
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alyacen 1/35

Products Affected

- *alyacen 1/35*

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

Alyacen 7/7/7

Products Affected

- *alyacen 7/7/7*

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

Ambien

Products Affected

- AMBIEN ORAL TABLET 10 MG

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ambien

Products Affected

- AMBIEN ORAL TABLET 5 MG

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ambien CR

Products Affected

- AMBIEN CR

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amerge

Products Affected

- AMERGE

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

Amethia

Products Affected

- AMETHIA

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

Amethia Lo

Products Affected

- AMETHIA LO

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

Amitiza

Products Affected

- AMITIZA

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

Amlodipine Besylate-Valsartan

Products Affected

- *amlodipine besylate-valsartan*

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

Amlodipine-Valsartan-HCTZ

Products Affected

- *amlodipine-valsartan-hctz*

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

Amnesteem

Products Affected

- AMNESTEEM

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring ANDMember is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria:1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has received a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
ST Criteria	Trial of 1 generic oral antibiotic prescribed for the treatment of acne (i.e., minocycline or doxycycline)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

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

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine oral tablet 5 mg, 30 mg, 15 mg, 7.5 mg, 10 mg, 12.5 mg*

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

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine oral tablet 20 mg*

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

Ampyra

Products Affected

- AMPYRA

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

Amrix

Products Affected

- AMRIX

ST Criteria	Trial of one week each of two preferred alternatives (one of which should be cyclobenzaprine or cyclobenzaprine er)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amturnide

Products Affected

- AMTURNIDE

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

AndroGel

Products Affected

- ANDROGEL TRANSDERMAL 50 MG/5GM (1%), 40.5 MG/2.5GM (1.62%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	60 packs Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	30 pack Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	30 packs Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel Pump

Products Affected

- ANDROGEL PUMP TRANSDERMAL 12.5 MG/ACT (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 pumps Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel Pump

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 pumps Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Angeliq

Products Affected

- ANGELIQ

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

Anoro Ellipta

Products Affected

- ANORO ELLIPTA

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

Antara

Products Affected

- ANTARA

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Antibiotic Ear

Products Affected

- *antibiotic ear*

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

Anzemet

Products Affected

- ANZEMET ORAL

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

APAP-Caff-Dihydrocodeine

Products Affected

- *apap-caff-dihydrocodeine oral capsule*

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

Apidra

Products Affected

- APIDRA

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of the preferred alternative Humalog product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apidra SoloStar

Products Affected

- APIDRA SOLOSTAR

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of the preferred alternative Humalog product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aplenzin

Products Affected

- APLENZIN

ST Criteria	Trial of 1 of budeprion sr/ xl, bupropion/ sr/ xl, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine/ sr, mirtazapine, selfemra, sertraline, venlafaxine sr capsule, or venlafaxine
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apri

Products Affected

- APRI

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

Apriso

Products Affected

- APRISO

ST Criteria	Trial of 1 month of Asacol, Asacol HD, Delzicol, Lialda, OR Pentasa (NSO)
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aptensio XR

Products Affected

- APTENSIO XR

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

Aralen

Products Affected

- ARALEN

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: malaria rheumatoid arthritis systemic and discoid lupus erythematosus scleroderma pemphigus lichen planus polymyositis sarcoidosis porphyria cutanea tarda amebiasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	
QL Criteria	30 days minimum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aranelle

Products Affected

- ARANELLE

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

Arcapta Neohaler

Products Affected

- ARCAPTA NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of Foradil AND Serevent
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aricept

Products Affected

- ARICEPT

ST Criteria	Trial of one month generic donepezil or donepezil ODT
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aricept ODT

Products Affected

- ARICEPT ODT

ST Criteria	Trial of one month generic donepezil or donepezil ODT
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ARIPiprazole

Products Affected

- *aripiprazole oral solution*

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

ARIPiprazole

Products Affected

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

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

ARIPiprazole

Products Affected

- *aripiprazole oral tablet dispersible*

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

Arixtra

Products Affected

- ARIXTRA

PA Criteria	Criteria Details
Covered Uses	For coverage of additional quantities over 21 day supply: 1. Perioperative management of oral anticoagulation when an invasive procedure is required based on risk 2. Prevention of VTE in patients undergoing cancer surgery and greater than 60 years of age OR who have previously experienced a VTE 3. Orthopaedic procedures, i.e. Elective hip arthroplasty or fracture repair, elective knee arthroplasty, knee arthroscopy in a high risk patient, elective spine surgery in a high risk patient 4. Treatment of VTE, PE, Superficial thrombophlebitis 5. Pregnancy 6. Neonates with VTE or children greater than 2 months of age experiencing idiopathic or secondary thromboembolism 7. Acute ST-elevated MI 8. Cancer 9. Long Distance Travel 10. Heparin Induced Thrombocytopenia (HIT) (Arixtra only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arnuity Ellipta

Products Affected

- ARNUITY ELLIPTA

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Medical Exception for Flovent Diskus, Flovent HFA, and Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Trial and failure of 1 month Asmanex and QVAR
QL Criteria	1 blister Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asacol HD

Products Affected

- ASACOL HD

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

Atacand

Products Affected

- ATACAND ORAL TABLET 32 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan OR Heart failure AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, candesartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	HTN: Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan HF: Candesartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atacand

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan OR Heart failure AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, candesartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	HTN: Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan HF: Candesartan
QL Criteria	2 tab Per 1 Day
Notes/ References	

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

Atacand HCT

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atacand HCT

Products Affected

- ATACAND HCT ORAL TABLET 16-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atelvia

Products Affected

- ATELVIA

QL Criteria	1 tab Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

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

Atovaquone-Proguanil HCl

Products Affected

- *atovaquone-proguanil hcl oral tablet 250-100 mg*

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Malaria medications are Certificate of Cover age (COC) Excluded for travel prophylaxis.
Required Medical Information	A documented diagnosis of malaria
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atralin

Products Affected

- ATRALIN

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Tretinoin and one of the following: adapalene, benzoyl peroxide, topical clindamycin, topical erythromycin, sulfacetamide w/sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aubagio

Products Affected

- AUBAGIO

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

Aubra

Products Affected

- AUBRA

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

Auvi-Q

Products Affected

- AUVI-Q

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

Avalide

Products Affected

- AVALIDE ORAL TABLET 300-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avalide

Products Affected

- AVALIDE ORAL TABLET 150-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avandamet

Products Affected

- AVANDAMET

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus in adults, AND A documented HbA1C lab value greater than 6.5%, AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of metformin AND a GLP-1 agonist (i.e., Bydureon), or a DPP-4 inhibitor (i.e., Januvia), or insulin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avandaryl

Products Affected

- AVANDARYL

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus in adults, AND A documented HbA1C lab value greater than 6.5%, AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of metformin AND a GLP-1 agonist (i.e., Bydureon), or a DPP-4 inhibitor (i.e., Januvia), or insulin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avandia

Products Affected

- AVANDIA

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus in adults, AND A documented HbA1C lab value greater than 6.5%, AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of metformin AND a GLP-1 agonist (i.e., Bydureon), or a DPP-4 inhibitor (i.e., Januvia), or insulin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avapro

Products Affected

- AVAPRO ORAL TABLET 150 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan OR Diabetic nephropathy AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of the preferred generic alternatives, irbesartan and losartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: Trial of a single entity from the above and its own hydrochlorothiazide combination does not qualify for meeting the requirement of trying two alternatives. Trial requires two different drugs (different chemical entities), either as single entity or in combination.
ST Criteria	HTN: Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan DPN: Irbesartan and losartan
QL Criteria	1 tab Per 1 Day

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

Avapro

Products Affected

- AVAPRO ORAL TABLET 300 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan OR Diabetic nephropathy AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of the preferred generic alternatives, irbesartan and losartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: Trial of a single entity from the above and its own hydrochlorothiazide combination does not qualify for meeting the requirement of trying two alternatives. Trial requires two different drugs (different chemical entities), either as single entity or in combination.
ST Criteria	HTN: Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan DPN: Irbesartan and losartan
Notes/ References	

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

Aviane

Products Affected

- AVIANE

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

Avidoxy

Products Affected

- *avidoxy*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AVINza

Products Affected

- AVINZA

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avita

Products Affected

- AVITA

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Tretinoin and one of the following: adapalene, benzoyl peroxide, topical clindamycin, topical erythromycin, sulfacetamide w/sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avodart

Products Affected

- AVODART

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member is NOT pregnant AND Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Axert

Products Affected

- AXERT

ST Criteria	Trial of 1 month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
QL Criteria	6 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Axiron

Products Affected

- AXIRON

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	6 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AzaSite

Products Affected

- AZASITE

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

Azilect

Products Affected

- AZILECT

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

Azor

Products Affected

- AZOR

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any two from the following: candesartan in combination with amlodipine eprosartan in combination with amlodipine irbesartan in combination with amlodipine losartan in combination with amlodipine valsartan in combination with amlodipine telmisartan in combination with amlodipine telmisartan/ amlodipine OR Exforge
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Azulfidine

Products Affected

- AZULFIDINE

ST Criteria	Trial of 1 month of Asacol, Asacol HD, Delzicol, Lialda, OR Pentasa (NSO)
QL Criteria	8 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Azulfidine EN-tabs

Products Affected

- AZULFIDINE EN-TABS

ST Criteria	Trial of 1 month of Asacol, Asacol HD, Delzicol, Lialda, OR Pentasa (NSO)
QL Criteria	8 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Azurette

Products Affected

- AZURETTE

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

Balsalazide Disodium

Products Affected

- *balsalazide disodium*

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

Balziva

Products Affected

- BALZIVA

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

Banzel

Products Affected

- BANZEL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory?(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities for those members who meet the following criterion: 1) Patient?s dose is being titrated by the physician OR does the patient require higher doses of the requested drug after failure of recommended standard doses.
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Banzel

Products Affected

- BANZEL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory?(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities for those members who meet the following criterion: 1) Patient?s dose is being titrated by the physician OR does the patient require higher doses of the requested drug after failure of recommended standard doses.
QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Beconase AQ

Products Affected

- BECONASE AQ

ST Criteria	Trial of 2 weeks each of 2 of Nasonex, budesonide, flunisolide, fluticasone, OR triamcinolone.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Belsomra

Products Affected

- BELSOMRA

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benicar

Products Affected

- BENICAR ORAL TABLET 5 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benicar

Products Affected

- BENICAR ORAL TABLET 40 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benicar HCT

Products Affected

- BENICAR HCT ORAL TABLET 20-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benicar HCT

Products Affected

- BENICAR HCT ORAL TABLET 40-25 MG, 40-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benzamycin

Products Affected

- BENZAMYCIN

ST Criteria	Trial of one month of the preferred generic alternative, benzoyl peroxide/clindamycin phosphate gel OR benzoyl peroxide/erythromycin gel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

BenzamycinPak

Products Affected

- BENZAMYCINPAK

ST Criteria	Trial of one month of the preferred generic alternative, benzoyl peroxide/clindamycin phosphate gel OR benzoyl peroxide/erythromycin gel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bimatoprost

Products Affected

- *bimatoprost ophthalmic*

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

Binosto

Products Affected

- BINOSTO

ST Criteria	Trial of one month each of two alendronate AND Actonel or Actonel with calcium OR Atelvia
QL Criteria	1 tab Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Blephamide

Products Affected

- BLEPHAMIDE

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

Boniva

Products Affected

- BONIVA ORAL

ST Criteria	Trial of one month each of two ibandronate AND Actonel OR Actonel with Calcium OR Atelvia
QL Criteria	1 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Breo Ellipta

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Chronic Ostructive Pulmonary Disease (COPD) Asthma
Exclusion Criteria	
Required Medical Information	A documented diagnosis of COPD or Asthma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	COPD: Trial of 1 month each of Symbicort AND Spiriva Asthma: Trial of 1 month each of Symbicort AND Dulera
QL Criteria	1 inhaler Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Breo Ellipta

Products Affected

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

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

Briellyn

Products Affected

- *briellyn*

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

Brilinta

Products Affected

- BRILINTA

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

Brilinta

Products Affected

- BRILINTA

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

Brintellix

Products Affected

- BRINTELLIX

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Brisdelle

Products Affected

- BRISDELLE

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause, AND A documented contraindication to menopausal hormone therapy (i.e., estradiol, Premarin), such as current, past or suspected breast cancer, estrogen-dependent neoplasia, genital bleeding, endometrial hyperplasia, thromboembolic disease, liver dysfunction, hypersensitivity to menopausal hormone therapy, or porphyria cutanea tarda, AND A documented contraindication or intolerance or allergy to the preferred generic alternative, paroxetine
Exclusion Criteria	
Required Medical Information	Brisdelle is not indicated for the treatment of any psychiatric condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of paroxetine
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Brovana

Products Affected

- BROVANA

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of Foradil AND Serevent
QL Criteria	60 vials (120ml) Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Budeprion SR

Products Affected

- BUDEPRION SR

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

Budeprion XL

Products Affected

- BUDEPRION XL

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

Budesonide

Products Affected

- *budesonide inhalation suspension 1 mg/2ml*

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

Budesonide ER

Products Affected

- *budesonide er*

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

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

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

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 6.3-1 MG

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

Bunavail

Products Affected

- BUNAVAIL BUCCAL FILM 4.2-0.7 MG

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

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual tablet sublingual*
  8 mg

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	8 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual tablet sublingual*
  2 mg

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	24 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	90 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

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

BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

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

BuPROPion HCl ER (XL)

Products Affected

- *bupropion hcl er (xl)*

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

Butorphanol Tartrate

Products Affected

- *butorphanol tartrate nasal*

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

Butrans

Products Affected

- BUTRANS

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

Bydureon

Products Affected

- BYDUREON

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

Bydureon

Products Affected

- BYDUREON

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

Byetta 10 MCG Pen

Products Affected

- BYETTA 10 MCG PEN

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

Byetta 5 MCG Pen

Products Affected

- BYETTA 5 MCG PEN

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

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

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

Calcitrene

Products Affected

- CALCITRENE

ST Criteria	Trial of one month of calcipotriene or Tazorac
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cambia

Products Affected

- CAMBIA

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

Camila

Products Affected

- CAMILA

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

Camrese

Products Affected

- CAMRESE

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

Camrese Lo

Products Affected

- CAMRESE LO

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

Canasa

Products Affected

- CANASA

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

Candesartan Cilexetil

Products Affected

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

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

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz oral tablet 16-12.5 mg*

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

Caprelsa

Products Affected

- CAPRELSA

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

Caziant

Products Affected

- CAZIANT

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

CeleBREX

Products Affected

- CELEBREX ORAL CAPSULE 400 MG, 50 MG, 100 MG

PA Criteria	Criteria Details
Covered Uses	Age greater than 60 OR Diagnosis of Juvenile Rheumatoid Arthritis [JRA] OR Concomitant use of warfarin (Coumadin?) or other anticoagulant/antiplatelet therapy OR Concomitant use of chronic oral (systemic) corticosteroid therapy (greater than 60 days) OR Documented history of ulcer disease** or GI bleed: OR Documented use of an H2 receptor antagonist (cimetidine/Tagamet?, famotidine/Pepcid?, nizatidine/Axid?, ranitidine/ Zantac?) or a proton pump inhibitor (AcipHex?, Nexium?, omeprazole/Prilosec?, Prevacid?, Protonix?), or misoprostol (Cytotec?) due to one of the following: History of significant GI disease** OR NSAID GI adverse effects, necessitating discontinuation of NSAID therapy
Exclusion Criteria	
Required Medical Information	For Celebrex 100 mg and 200 mg: A Documented diagnosis of rheumatoid arthritis (RA) or Juvenile Rheumatoid Arthritis [JRA] (approvable dose is 200 mg twice daily or 60 capsules (200mg) per 30 days) OR Failure of 200mg total daily dose (approvable dose is 200 mg twice daily or 60 capsules (200mg) per 30 days) OR Documented diagnosis of acute pain (approvable dose is 200 mg twice daily or 60 capsules (200 mg) per 30 days: 30 day limit)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year for chronic diagnosis 1 Month for acute pain
Other Criteria	
QL Criteria	2 caps Per 1 Day
Notes/ References	

Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CeleBREX

Products Affected

- CELEBREX ORAL CAPSULE 200 MG

PA Criteria	Criteria Details
Covered Uses	Age greater than 60 OR Diagnosis of Juvenile Rheumatoid Arthritis [JRA] OR Concomitant use of warfarin (Coumadin?) or other anticoagulant/antiplatelet therapy OR Concomitant use of chronic oral (systemic) corticosteroid therapy (greater than 60 days) OR Documented history of ulcer disease** or GI bleed: OR Documented use of an H2 receptor antagonist (cimetidine/Tagamet?, famotidine/Pepcid?, nizatidine/Axid?, ranitidine/ Zantac?) or a proton pump inhibitor (AcipHex?, Nexium?, omeprazole/Prilosec?, Prevacid?, Protonix?), or misoprostol (Cytotec?) due to one of the following: History of significant GI disease** OR NSAID GI adverse effects, necessitating discontinuation of NSAID therapy
Exclusion Criteria	
Required Medical Information	For Celebrex 100 mg and 200 mg: A Documented diagnosis of rheumatoid arthritis (RA) or Juvenile Rheumatoid Arthritis [JRA] (approvable dose is 200 mg twice daily or 60 capsules (200mg) per 30 days) OR Failure of 200mg total daily dose (approvable dose is 200 mg twice daily or 60 capsules (200mg) per 30 days) OR Documented diagnosis of acute pain (approvable dose is 200 mg twice daily or 60 capsules (200 mg) per 30 days: 30 day limit)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year for chronic diagnosis 1 Month for acute pain
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2015 Aetna Pharmacy Plan Drug List - Fully Insured
(Updated 12/01/15)

Celecoxib

Products Affected

- *celecoxib oral capsule 400 mg, 100 mg, 50 mg*

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

Celecoxib

Products Affected

- *celecoxib oral capsule 200 mg*

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

CeleXA

Products Affected

- CELEXA

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

Cenestin

Products Affected

- CENESTIN

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

Cerdelga

Products Affected

- CERDELGA

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

Cesamet

Products Affected

- CESAMET

QL Criteria	20 caps Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cesia

Products Affected

- CESIA

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

Chantix

Products Affected

- CHANTIX

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

Chantix Continuing Month Pak

Products Affected

- CHANTIX CONTINUING MONTH PAK

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

Chantix Starting Month Pak

Products Affected

- CHANTIX STARTING MONTH PAK

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

Chateal

Products Affected

- CHATEAL

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

Chloroquine Phosphate

Products Affected

- *chloroquine phosphate oral*

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: malaria rheumatoid arthritis systemic and discoid lupus erythematosus scleroderma pemphigus lichen planus polymyositis sarcoidosis porphyria cutanea tarda amebiasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	
QL Criteria	30 days minimum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciclodan

Products Affected

- CICLODAN

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 (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections: 12 weeks for toe nailinfections): fluconazole (6 months): griseofulvin (6 months): itraconazole (60 days (PulsePak) for fingernail infections: 90 days for toenail) OR Presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR Member is female and is pregnant and/or breastfeeding AND Member is NOT receiving a systemic (oral) antifungal agent ? terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciclopirox

Products Affected

- *ciclopirox*

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 (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections: 12 weeks for toe nailinfections): fluconazole (6 months): griseofulvin (6 months): itraconazole (60 days (PulsePak) for fingernail infections: 90 days for toenail) OR Presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR Member is female and is pregnant and/or breastfeeding AND Member is NOT receiving a systemic (oral) antifungal agent ? terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciclopirox Olamine

Products Affected

- *ciclopirox olamine external*

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 (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections: 12 weeks for toe nailinfections): fluconazole (6 months): griseofulvin (6 months): itraconazole (60 days (PulsePak) for fingernail infections: 90 days for toenail) OR Presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR Member is female and is pregnant and/or breastfeeding AND Member is NOT receiving a systemic (oral) antifungal agent ? terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciloxan

Products Affected

- CILOXAN OPHTHALMIC SOLUTION

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

Cipro

Products Affected

- CIPRO ORAL SUSPENSION RECONSTITUTED
- CIPRO ORAL TABLET 250 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cipro HC

Products Affected

- CIPRO HC

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

Cipro XR

Products Affected

- CIPRO XR

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciprodex

Products Affected

- CIPRODEX

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

Ciprofloxacin HCl

Products Affected

- *ciprofloxacin hcl ophthalmic*

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

Ciprofloxacin HCl

Products Affected

- *ciprofloxacin hcl oral*

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciprofloxacin-Ciproflox HCl ER

Products Affected

- *ciprofloxacin-ciproflox hcl er*

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet*

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

Claravis

Products Affected

- CLARAVIS

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring ANDMember is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria:1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has received a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
ST Criteria	Trial of 1 generic oral antibiotic prescribed for the treatment of acne (i.e., minocycline or doxycycline)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarinex

Products Affected

- CLARINEX ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarinex

Products Affected

- CLARINEX ORAL SYRUP

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	10 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarinex Reditabs

Products Affected

- CLARINEX REDITABS

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarinex-D 12 Hour

Products Affected

- CLARINEX-D 12 HOUR

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarinex-D 24 Hour

Products Affected

- CLARINEX-D 24 HOUR

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Climara

Products Affected

- CLIMARA

QL Criteria	1 patch Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Climara Pro

Products Affected

- CLIMARA PRO

QL Criteria	1 patch Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clobex

Products Affected

- CLOBEX

ST Criteria	Trial of two weeks of clobetasol lotion OR clobetasol shampoo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clobex Spray

Products Affected

- CLOBEX SPRAY

ST Criteria	Trial of two weeks of clobetasol lotion OR clobetasol shampoo
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CloNIDine HCl ER

Products Affected

- *clonidine hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA-diagnosis required for members greater than 18 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate oral tablet 75 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet 50 mg, 25 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 200 mg*
- *clozapine oral tablet 200 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet 100 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg*

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

Clozaril

Products Affected

- CLOZARIL ORAL TABLET 100 MG

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

Clozaril

Products Affected

- CLOZARIL ORAL TABLET 25 MG

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

Coartem

Products Affected

- COARTEM

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Malaria medications are Certificate of Cover age (COC) Excluded for travel prophylaxis.
Required Medical Information	A documented diagnosis of malaria
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Colazal

Products Affected

- COLAZAL

ST Criteria	Trial of 1 month of Asacol, Asacol HD, Delzicol, Lialda, OR Pentasa (NSO)
QL Criteria	9 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Colcrys

Products Affected

- COLCRYS

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

Coly-Mycin S

Products Affected

- COLY-MYCIN S

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

CombiPatch

Products Affected

- COMBIPATCH

QL Criteria	8 patch Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Combivent Respimat

Products Affected

- COMBIVENT RESPIMAT

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Combivent Respimat (propellant-free inhaler)
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Combivir

Products Affected

- COMBIVIR

ST Criteria	Trial of one month of the medication's preferred generic equivalent alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cometriq (100 mg Daily Dose)

Products Affected

- COMETRIQ (100 MG DAILY DOSE)

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

Cometriq (140 mg Daily Dose)

Products Affected

- COMETRIQ (140 MG DAILY DOSE)

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

Cometriq (60 mg Daily Dose)

Products Affected

- COMETRIQ (60 MG DAILY DOSE)

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

Concerta

Products Affected

- CONCERTA ORAL TABLET EXTENDEDRELEASE* 18 MG, 27 MG, 54 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Concerta

Products Affected

- CONCERTA ORAL TABLET EXTENDEDRELEASE* 36 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ConZip

Products Affected

- CONZIP

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

Corlanor

Products Affected

- CORLANOR

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

Cortisporin

Products Affected

- CORTISPORIN OTIC

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

Cortisporin-TC

Products Affected

- CORTISPORIN-TC

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

Cozaar

Products Affected

- COZAAR ORAL TABLET 25 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan OR Diabetic nephropathy AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of the preferred generic alternatives, irbesartan and losartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: Trial of a single entity from the above and its own hydrochlorothiazide combination does not qualify for meeting the requirement of trying two alternatives. Trial requires two different drugs (different chemical entities), either as single entity or in combination.
ST Criteria	HTN: Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan DPN: Irbesartan and losartan
QL Criteria	2 tab Per 1 Day

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

Crestor

Products Affected

- CRESTOR

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

Cryselle-28

Products Affected

- CRYSELLE-28

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

Cutivate

Products Affected

- CUTIVATE

ST Criteria	Trial of two weeks of one alternative generic: - betamethasone benzoate betamethasone dipropionate betamethasone valerate desonide lotion desonide desoximetasone fluocinolone acetonide fluticasone fluocinonide hydrocortisone butyrate hydrocortisone valerate prednicarbate OR triamcinolone acetonide
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cyclafem 1/35

Products Affected

- CYCLAFEM 1/35

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

Cyclafem 7/7/7

Products Affected

- CYCLAFEM 7/7/7

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

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 60 MG

ST Criteria	Trial of one month of one: budeprion SR/XL bupropion/SR/XL citalopram escitalopram fluoxetine fluvoxamine paroxetine/sr mirtazapine selfemra sertraline venlafaxine venlafaxine er tablet venlafaxine sr cap
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cymbalta

Products Affected

- CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 20 MG, 30 MG

ST Criteria	Trial of one month of one: budeprion SR/XL bupropion/SR/XL citalopram escitalopram fluoxetine fluvoxamine paroxetine/sr mirtazapine selfemra sertraline venlafaxine venlafaxine er tablet venlafaxine sr cap
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daklinza

Products Affected

- DAKLINZA

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

Daliresp

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	COPD
Exclusion Criteria	
Required Medical Information	A documented diagnosis of severe (Stage III) or very severe (Stage IV) chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and a history of exacerbations AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one week of one preferred alternative bronchodilator, albuterol/ ipratropium, ipratropium inhalation solution, or Combivent Respimat AND Spiriva AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred alternative bronchodilator, Symbicort
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Diagnosis of severe (Stage III) or very severe (Stage IV) chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and a history of exacerbations AND contraindication or intolerance or allergy or failure of an adequate trial of one week of one preferred alternative bronchodilator, albuterol/ ipratropium, ipratropium inhalation solution, or Combivent Respimat AND Spiriva AND contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred alternative bronchodilator, Symbicort
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daraprim

Products Affected

- DARAPRIM

PA Criteria	Criteria Details
Covered Uses	Malaria Toxoplasmosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: malaria toxoplasmosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	
QL Criteria	30 days minimum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dasetta 1/35

Products Affected

- DASETTA 1/35

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

Dasetta 7/7/7

Products Affected

- DASETTA 7/7/7

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

Daysee

Products Affected

- DAYSEE

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

Daytrana

Products Affected

- DAYTRANA

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 patch Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Delzicol

Products Affected

- DELZICOL

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

Demeclocycline HCl

Products Affected

- *demeclocycline hcl oral*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Depo-Provera

Products Affected

- DEPO-PROVERA INTRAMUSCULAR*
  SUSPENSION 150 MG/ML

QL Criteria	5 vial Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Depo-SubQ Provera 104

Products Affected

- DEPO-SUBQ PROVERA 104

QL Criteria	8 syringe Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desloratadine

Products Affected

- *desloratadine*

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desmopressin Ace Rhinal Tube

Products Affected

- *desmopressin ace rhinal tube*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of central diabetes insipidus (neurohypophyseal diabetes insipidus) including polydipsia and polyuria
Exclusion Criteria	
Required Medical Information	
Age Restrictions	less than 17
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Under some plans, including plans that use an open or closed formulary, DDAVP nasal/injection/tablets are subject to step-therapy. Aetna considers DDAVP nasal/injection/tablets to be medically necessary for those members who meet the following step-therapy criterion: Trial of one month of the generic alternative agent desmopressin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desmopressin Ace Spray Refrig

Products Affected

- *desmopressin ace spray refrig*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of central diabetes insipidus (neurohypophyseal diabetes insipidus) including polydipsia and polyuria
Exclusion Criteria	
Required Medical Information	
Age Restrictions	less than 17
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Under some plans, including plans that use an open or closed formulary, DDAVP nasal/injection/tablets are subject to step-therapy. Aetna considers DDAVP nasal/injection/tablets to be medically necessary for those members who meet the following step-therapy criterion: Trial of one month of the generic alternative agent desmopressin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desmopressin Acetate

Products Affected

- *desmopressin acetate oral*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of central diabetes insipidus (neurohypophyseal diabetes insipidus) including polydipsia and polyuria
Exclusion Criteria	
Required Medical Information	
Age Restrictions	less than 17
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Under some plans, including plans that use an open or closed formulary, DDAVP nasal/injection/tablets are subject to step-therapy. Aetna considers DDAVP nasal/injection/tablets to be medically necessary for those members who meet the following step-therapy criterion: Trial of one month of the generic alternative agent desmopressin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desmopressin Acetate Spray

Products Affected

- *desmopressin acetate spray*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of central diabetes insipidus (neurohypophyseal diabetes insipidus) including polydipsia and polyuria
Exclusion Criteria	
Required Medical Information	
Age Restrictions	less than 17
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Under some plans, including plans that use an open or closed formulary, DDAVP nasal/injection/tablets are subject to step-therapy. Aetna considers DDAVP nasal/injection/tablets to be medically necessary for those members who meet the following step-therapy criterion: Trial of one month of the generic alternative agent desmopressin
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desogestrel-Ethinyl Estradiol

Products Affected

- *desogestrel-ethinyl estradiol*

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

Desonate

Products Affected

- DESONATE

ST Criteria	Trial of two weeks of one generic desonide alternative any dosage form
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desoxyn

Products Affected

- DESOXYN

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	4 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desvenlafaxine ER

Products Affected

- *desvenlafaxine er*

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Detrol LA

Products Affected

- DETROL LA

ST Criteria	Trial of 1 month each of trospium/er OR tolteridine/er AND Myrbetriq AND Vesicare
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexedrine

Products Affected

- DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexilant

Products Affected

- DEXILANT

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

Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
QL Criteria	4 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

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

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

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

Diastat AcuDial

Products Affected

- DIASTAT ACUDIAL

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

Diastat Pediatric

Products Affected

- DIASTAT PEDIATRIC

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

Diclegis

Products Affected

- DICLEGIS

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

Diclofenac Sodium

Products Affected

- *diclofenac sodium ophthalmic*

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

Differin

Products Affected

- DIFFERIN

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of adapalene cream or gel 0.1%
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Differin

Products Affected

- DIFFERIN

ST Criteria	Trial of one month of Retin-A MICRO
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dificid

Products Affected

- DIFICID

PA Criteria	Criteria Details
Covered Uses	Clostridium difficile infection
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Clostridium difficile associated diarrhea in adults greater than 18 years of age AND A documented: Contraindication to preferred agents metronidazole or oral vancomycin hydrochloride indicated for the member's condition OR Intolerance to metronidazole or oral vancomycin hydrochloride indicated for member?s condition OR Allergy to metronidazole or oral vancomycin hydrochloride indicated for the member's condition OR Failure of an adequate trial of 10 days of metronidazole or 7 days of oral vancomycin hydrochloride OR Discharge from hospital or medical facility due to a documented diagnosis from above AND documented initial treatment with Dificid while in the hospital/medical facility.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
QL Criteria	20 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diflucan

Products Affected

- DIFLUCAN

PA Criteria	Criteria Details
Covered Uses	Bone marrow transplant - Candidiasis: Prophylaxis Candidal vulvovaginitis Candidiasis Cryptococcal meningitis Oropharyngeal candidiasis
Exclusion Criteria	Diflucan 150mg not included

PA Criteria	Criteria Details
Required Medical Information	A documented diagnosis of 1 of the below indications & specified criteria AND A documented contraindication/intolerance/allergy/failure of an adequate trial of generic fluconazole (if request is for brand Diflucan) Blastomycosis Bone Marrow Transplant (prophylaxis) Candidiasis (Systemic): Chronic cutaneous candidal infection Coccidoidmycosis or Coccidiomeningitis Chronic Candidal Paronychia Cryptococcus Cutaneous dermatophyte infection: NOTE: tinea pedis (athletes foot), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor AND A documented contraindication/intolerance/allergy/failure of an adequate trial of 1 topical antifungal AND oral terbinafine Fungal Otitis externa AND A documented contraindication/intolerance/allergy/failure of an adequate trial of 1 week of one preferred topical alternative Histoplasmosis HIV or Cancer Mastitis or a candidal infection of the breast (due to breast feeding/oral thrush in the infant) Tinea capitis AND A documented contraindication/intolerance/allergy/failure of 2 weeks of generic terbinafine Tinea versicolor Urinary tract infection with Candida or Balanitis with Candida Vulvovaginal candidiasis (Vaginal Yeast Infection) Oral (thrush), esophageal, intestinal candidiasis Onychomycosis (Tinea unguium) due to dermatophyte AND A documented positive lab test such as a KOH preparation, fungal culture, or nail biopsy (NOTE: This positive test should be within the last 3-6 months & associated with the current infection) AND A documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic terbinafine OR any of the following: Presence of hepatic dysfunction or increased risk for liver disease Fungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection) AND A documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic itraconazole
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities of Diflucan, fluconazole, or Oravig for those members who meet ANY of the following criteria: For member that has a diagnosis of vulvovaginal candidiasis (VVC)/Vaginal Yeast Infection complicated with any of the following: antibiotic use or an immune compromised state such as HIV/AIDS or diabetes, or cancer, or chronic corticosteroid use: or recurrent (4 or more episodes per year) or severe VVC as determined by the physician ? for fluconazole/Diflucan (approval of 30 in 30 days for 1 year will be allowed)
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diovan

Products Affected

- DIOVAN ORAL TABLET 40 MG, 160 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan OR Heart failure AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, candesartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	HTN: Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan HF: Candesartan
QL Criteria	2 tab Per 1 Day
Notes/ References	

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

Diovan

Products Affected

- DIOVAN ORAL TABLET 320 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan OR Heart failure AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, candesartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	HTN: Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan HF: Candesartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diovan HCT

Products Affected

- DIOVAN HCT ORAL TABLET 160-25 MG, 80-12.5 MG, 160-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diovan HCT

Products Affected

- DIOVAN HCT ORAL TABLET 320-12.5 MG, 320-25 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dipentum

Products Affected

- DIPENTUM

ST Criteria	Trial of 1 month of Asacol, Asacol HD, Delzicol, Lialda, OR Pentasa (NSO)
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ditropan XL

Products Affected

- DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HR* 10 MG, 15 MG

ST Criteria	Trial of 1 month each of trospium/er OR tolteridine/er AND Myrbetriq AND Vesicare
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ditropan XL

Products Affected

- DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HR* 5 MG

ST Criteria	Trial of 1 month each of trospium/er OR tolteridine/er AND Myrbetriq AND Vesicare
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dolophine

Products Affected

- DOLOPHINE ORAL TABLET 5 MG

QL Criteria	180 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Doryx

Products Affected

- DORYX

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Doxycycline

Products Affected

- *doxycycline*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Doxycycline Hyclate

Products Affected

- *doxycycline hyclate oral capsule*
- *doxycycline hyclate oral tablet*
- *doxycycline hyclate oral tablet delayed release*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Doxycycline Monohydrate

Products Affected

- *doxycycline monohydrate*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Drospirenone-Ethinyl Estradiol

Products Affected

- *drospirenone-ethinyl estradiol oral tablet 3-0.03 mg*

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

Duac

Products Affected

- DUAC

ST Criteria	Trial of one month of the preferred generic alternative, benzoyl peroxide/clindamycin phosphate gel OR benzoyl peroxide/erythromycin gel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Duavee

Products Affected

- DUAVEE

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

Duetact

Products Affected

- DUETACT

ST Criteria	Trial of one month of pioglitazone/glimeperide
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Duexis

Products Affected

- DUEXIS

ST Criteria	Trial of two weeks of one generic nonsteroidal anti-inflammatory agent
QL Criteria	3 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dulera

Products Affected

- DULERA

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

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg*

ST Criteria	Trial of one month of at least one of the following: Budeprion SR, Budeprion XL, bupropion, bupropion SR, bupropion XL, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine extended-release, mirtazapine, sertraline, venlafaxine, or venlafaxine ER capsule
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

DULoxetine HCl

Products Affected

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

ST Criteria	Trial of one month of at least one of the following: Budeprion SR, Budeprion XL, bupropion, bupropion SR, bupropion XL, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine extended-release, mirtazapine, sertraline, venlafaxine, or venlafaxine ER capsule
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

DULoxetine HCl

Products Affected

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

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

Duragesic-100

Products Affected

- DURAGESIC-100

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate
QL Criteria	2 patches Per 3 Days

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

Duragesic-12

Products Affected

- DURAGESIC-12

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate
QL Criteria	2 patches Per 3 Days

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

Duragesic-25

Products Affected

- DURAGESIC-25

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate
QL Criteria	2 patches Per 3 Days

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

Duragesic-50

Products Affected

- DURAGESIC-50

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate
QL Criteria	2 patches Per 3 Days

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

Duragesic-75

Products Affected

- DURAGESIC-75

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate
QL Criteria	2 patches Per 3 Days

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

Dutasteride

Products Affected

- *dutasteride*

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

Edarbi

Products Affected

- EDARBI

ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Edarbyclor

Products Affected

- EDARBYCLOR

ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Edluar

Products Affected

- EDLUAR

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Effexor XR

Products Affected

- EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 150 MG

ST Criteria	Trial of one month of the generic equivalent alternative
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Effexor XR

Products Affected

- EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 75 MG, 37.5 MG

ST Criteria	Trial of one month of the generic equivalent alternative
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Effient

Products Affected

- EFFIENT

PA Criteria	Criteria Details
Covered Uses	Acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI]) managed by percutaneous coronary intervention (PCI)
Exclusion Criteria	History of Stroke or TIA
Required Medical Information	Member has a documented diagnosis of acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI]) managed by percutaneous coronary intervention (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 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elestrin

Products Affected

- ELESTRIN

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

Elidel

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	atopic dermatitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild to moderate atopic dermatitis in patients (eczema) less than 2 years of age for short-term use (up to 3 months) (Note: requirement of a trial of topical corticosteroid is not required) OR A documented diagnosis of atopic dermatitis (eczema) in an adult or child 2 years of age or older, AND one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient?s condition, OR A documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient?s condition, OR Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For face, eyelids, genital areas:3 months,All other areas:6 months,Patients under 2 yrs: 3 months
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elinest

Products Affected

- ELINEST

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

Eliquis

Products Affected

- ELIQUIS

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

Ella

Products Affected

- ELLA

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

Elmiron

Products Affected

- ELMIRON

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

Embeda

Products Affected

- EMBEDA

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emend

Products Affected

- EMEND ORAL CAPSULE 40 MG, 125 MG

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

Emend

Products Affected

- EMEND ORAL CAPSULE 80 & 125 MG

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

Emend

Products Affected

- EMEND ORAL CAPSULE 80 MG

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

Emoquette

Products Affected

- EMOQUETTE

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

Emsam

Products Affected

- EMSAM

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

Enjuvia

Products Affected

- ENJUVIA

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

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium*

PA Criteria	Criteria Details
Covered Uses	For coverage of additional quantities over 21 day supply: 1. Perioperative management of oral anticoagulation when an invasive procedure is required based on risk 2. Prevention of VTE in patients undergoing cancer surgery and greater than 60 years of age OR who have previously experienced a VTE 3. Orthopaedic procedures, i.e. Elective hip arthroplasty or fracture repair, elective knee arthroplasty, knee arthroscopy in a high risk patient, elective spine surgery in a high risk patient 4. Treatment of VTE, PE, Superficial thrombophlebitis 5. Pregnancy 6. Neonates with VTE or children greater than 2 months of age experiencing idiopathic or secondary thromboembolism 7. Acute ST-elevated MI 8. Cancer 9. Long Distance Travel 10. Heparin Induced Thrombocytopenia (HIT) (Arixtra only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 syringes Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enpresse-28

Products Affected

- ENPRESSE-28

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

Enskyce

Products Affected

- ENSKYCE

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

Entocort EC

Products Affected

- ENTOCORT EC

ST Criteria	Trial of one month of generic budesonide SR
QL Criteria	3 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Entresto

Products Affected

- ENTRESTO

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

Epaned

Products Affected

- EPANED

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension (HTN), AND Member has a documented inability to swallow a tablet or capsule and no other route of administration exists (i.e., NG-tube, G-tube, J-tube)
Age Restrictions	greater than 5
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of three preferred generic alternative: angiotensin-converting enzyme inhibitors (ACEI) OR hydrochlorothiazide combinations (ACEI/ HCTZ) Note: Trial of a single entity ACEI and its own hydrochlorothiazide combination does not qualify for meeting the requirement of trying three alternatives. Trial requires three different drugs (different chemical entities), either as single entity or in combination.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Epiduo

Products Affected

- EPIDUO

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EpiPen 2-Pak

Products Affected

- EPIPEN 2-PAK

PA Criteria	Criteria Details
Covered Uses	emergency treatment of severe allergic reactions including anaphylaxis
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 doses Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EpiPen Jr 2-Pak

Products Affected

- EPIPEN JR 2-PAK

PA Criteria	Criteria Details
Covered Uses	emergency treatment of severe allergic reactions including anaphylaxis
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 doses Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Erivedge

Products Affected

- ERIVEDGE

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

Errin

Products Affected

- ERRIN

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

Esbriet

Products Affected

- ESBRIET

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet*

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral solution*

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

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium oral capsule delayed release 40 mg*

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Esomeprazole Strontium

Products Affected

- *esomeprazole strontium oral capsule delayed release 49.3 mg*

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estarylla

Products Affected

- ESTARYLLA

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

Estradiol

Products Affected

- *estradiol transdermal patch weekly*

QL Criteria	1 patch Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estrasorb

Products Affected

- ESTRASORB

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

Estrogel

Products Affected

- ESTROGEL

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

Eszopiclone

Products Affected

- *eszopiclone*

PA Criteria	Criteria Details
Covered Uses	Insomnia, in members over age 18
Exclusion Criteria	
Required Medical Information	
Age Restrictions	not covered less than 18 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month of a generic hypnotic (i.e., zolpidem, temazepam, triazolam)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Evamist

Products Affected

- EVAMIST

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

Evekeo

Products Affected

- EVEKEO

PA Criteria	Criteria Details
Covered Uses	ADHD Narcolepsy Obesity (only if benefit rider applies)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (ADHD/Narcolepsy) 12 weeks (obesity)
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	120 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Evista

Products Affected

- EVISTA

ST Criteria	Trial of one month of generic raloxifene
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Evzio

Products Affected

- EVZIO

PA Criteria	Criteria Details
Covered Uses	Overdose of opiate
Exclusion Criteria	
Required Medical Information	Aetna considers Evzio medically necessary for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/ or central nervous system depression
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exalgo

Products Affected

- EXALGO ORAL 12 MG, 8 MG

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	2 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exalgo

Products Affected

- EXALGO ORAL 32 MG

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exalgo

Products Affected

- EXALGO ORAL 16 MG

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	4 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exforge

Products Affected

- EXFORGE

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

Exforge HCT

Products Affected

- EXFORGE HCT

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

Fabior

Products Affected

- FABIOR

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of two preferred alternatives indicated for the member's condition, one of which has to be tretinoin.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Factive

Products Affected

- FACTIVE

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Falmina

Products Affected

- FALMINA

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

Famciclovir

Products Affected

- *famciclovir oral tablet 125 mg, 250 mg*

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

Famciclovir

Products Affected

- *famciclovir oral tablet 500 mg*

QL Criteria	21 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Famvir

Products Affected

- FAMVIR ORAL TABLET 500 MG

QL Criteria	21 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Famvir

Products Affected

- FAMVIR ORAL TABLET 125 MG, 250 MG

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

Fanapt

Products Affected

- FANAPT

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fanapt Titration Pack

Products Affected

- FANAPT TITRATION PACK

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	8 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Farxiga

Products Affected

- FARXIGA

ST Criteria	Trial of one month of Invokana (single entity or combination)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Farydak

Products Affected

- FARYDAK

QL Criteria	12 capsules Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
  12.5 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
  200 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
  100 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
  150 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
  25 MG

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

FemCap

Products Affected

- FEMCAP

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

Femhrt 1/5

Products Affected

- FEMHRT 1/5

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

Femhrt Low Dose

Products Affected

- FEMHRT LOW DOSE

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

Femring

Products Affected

- FEMRING

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

Fenoglide

Products Affected

- FENOGLIDE

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FentaNYL

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

QL Criteria	20 patches Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FentaNYL

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

QL Criteria	20 patch Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FentaNYL Citrate

Products Affected

- *fentanyl citrate buccal*

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

QL Criteria	15 lollipops Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fentora

Products Affected

- FENTORA

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one week each of the preferred generic alternative, fentanyl transmucosal lozenge AND two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
QL Criteria	15 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fetzima

Products Affected

- FETZIMA

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fetzima Titration

Products Affected

- FETZIMA TITRATION

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 titration pack Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fibricor

Products Affected

- FIBRICOR

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Finasteride

Products Affected

- *finasteride oral tablet 5 mg*

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	(Member is male) Age greater than 50 yrs old OR Member has diagnosis of BPH (Benign Prostatic Hyperplasia) (Member is female) Member is NOT pregnant AND Member has documented diagnosis of hirsutism secondary to ovarian or adrenal dysfunction (for example, polycystic ovary syndrome, adrenal or ovarian tumor) OR Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flector

Products Affected

- FLECTOR

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

Flomax

Products Affected

- FLOMAX

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member has documented diagnosis of Urethral syndrome (urinary hesitancy, frequency, and dysuria) OR Member has documented diagnosis of intractable micturition difficulties (difficulty passing urine) OR Member has documented diagnosis of Ureteral calculi/Kidney stones OR Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
ST Criteria	Trial of one month of thegeneric equivalent: tamsulosin
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flovent Diskus

Products Affected

- FLOVENT DISKUS

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Medical Exception for Flovent Diskus, Flovent HFA, and Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Trial of 1 month of Asmanex AND Qvar
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flovent HFA

Products Affected

- FLOVENT HFA

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Medical Exception for Flovent Diskus, Flovent HFA, and Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	Trial of 1 month of Asmanex AND Qvar
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral solution*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 40 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

QL Criteria	1 caps Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 60 mg*

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

Flurbiprofen Sodium

Products Affected

- *flurbiprofen sodium*

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

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

Fluvastatin Sodium ER

Products Affected

- *fluvastatin sodium er*

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

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

FluvoxaMINE Maleate

Products Affected

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

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

FluvoxaMINE Maleate ER

Products Affected

- *fluvoxamine maleate er*

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

Focalin

Products Affected

- FOCALIN

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Focalin XR

Products Affected

- FOCALIN XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium*

PA Criteria	Criteria Details
Covered Uses	For coverage of additional quantities over 21 day supply: 1. Perioperative management of oral anticoagulation when an invasive procedure is required based on risk 2. Prevention of VTE in patients undergoing cancer surgery and greater than 60 years of age OR who have previously experienced a VTE 3. Orthopaedic procedures, i.e. Elective hip arthroplasty or fracture repair, elective knee arthroplasty, knee arthroscopy in a high risk patient, elective spine surgery in a high risk patient 4. Treatment of VTE, PE, Superficial thrombophlebitis 5. Pregnancy 6. Neonates with VTE or children greater than 2 months of age experiencing idiopathic or secondary thromboembolism 7. Acute ST-elevated MI 8. Cancer 9. Long Distance Travel 10. Heparin Induced Thrombocytopenia (HIT) (Arixtra only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Foradil Aerolizer

Products Affected

- FORADIL AEROLIZER

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

Forfivo XL

Products Affected

- FORFIVO XL

ST Criteria	Trial of one month of one: budeprion SR/XL bupropion/SR/XL citalopram escitalopram fluoxetine fluvoxamine paroxetine/sr mirtazapine selfemra sertraline venlafaxine venlafaxine er tablet venlafaxine sr cap
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fortesta

Products Affected

- FORTESTA

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	4 GM Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fosamax

Products Affected

- FOSAMAX

QL Criteria	1 tab Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fosamax Plus D

Products Affected

- FOSAMAX PLUS D

ST Criteria	Trial of one month each of two alendronate AND Actonel or Actonel with calcium OR Atelvia
QL Criteria	1 tab Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fragmin

Products Affected

- FRAGMIN

PA Criteria	Criteria Details
Covered Uses	For coverage of additional quantities over 21 day supply: 1. Perioperative management of oral anticoagulation when an invasive procedure is required based on risk 2. Prevention of VTE in patients undergoing cancer surgery and greater than 60 years of age OR who have previously experienced a VTE 3. Orthopaedic procedures, i.e. Elective hip arthroplasty or fracture repair, elective knee arthroplasty, knee arthroscopy in a high risk patient, elective spine surgery in a high risk patient 4. Treatment of VTE, PE, Superficial thrombophlebitis 5. Pregnancy 6. Neonates with VTE or children greater than 2 months of age experiencing idiopathic or secondary thromboembolism 7. Acute ST-elevated MI 8. Cancer 9. Long Distance Travel 10. Heparin Induced Thrombocytopenia (HIT) (Arixtra only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Frova

Products Affected

- FROVA

ST Criteria	Trial of 1 month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
QL Criteria	9 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fulyzaq

Products Affected

- FULYZAQ

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

Fycompa

Products Affected

- FYCOMPA

PA Criteria	Criteria Details
Covered Uses	partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND Documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities for those members who meet the following criterion: 1) Patient?s dose is being titrated by the physician OR does the patient require higher doses of the requested drug after failure of recommended standard doses.
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gabapentin

Products Affected

- *gabapentin oral tablet*

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

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gabapentin

Products Affected

- *gabapentin oral solution*

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

Gabitril

Products Affected

- GABITRIL ORAL TABLET 16 MG

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

Gabitril

Products Affected

- GABITRIL ORAL TABLET 12 MG, 4 MG

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

Gabitril

Products Affected

- GABITRIL ORAL TABLET 2 MG

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

Garamycin

Products Affected

- GARAMYCIN OPHTHALMIC SOLUTION

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

Gatifloxacin

Products Affected

- *gatifloxacin*

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

Gentamicin Sulfate

Products Affected

- *gentamicin sulfate ophthalmic solution*

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

Geodon

Products Affected

- GEODON ORAL

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gianvi

Products Affected

- GIANVI

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

Giazo

Products Affected

- GIAZO

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

Gildagia

Products Affected

- GILDAGIA

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

Gildess 1.5/30

Products Affected

- GILDESS 1.5/30

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

Gildess 1/20

Products Affected

- GILDESS 1/20

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

Gildess FE 1.5/30

Products Affected

- GILDESS FE 1.5/30

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

Gildess FE 1/20

Products Affected

- GILDESS FE 1/20

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

Gilenya

Products Affected

- GILENYA

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

Gilotrif

Products Affected

- GILOTRIF

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

Gleevec

Products Affected

- GLEEVEC

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

Glycate

Products Affected

- GLYCATE

ST Criteria	Trial of one month of generic: glycopyrrolate
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glyxambi

Products Affected

- GLYXAMBI

ST Criteria	Trial of one month each of Invokana/Invokamet AND one of the following: Januvia OR Onglyza (single entity or combo)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise

Products Affected

- GRALISE ORAL TABLET 600 MG

ST Criteria	Trial of 1 month of gabapentin
QL Criteria	3 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise

Products Affected

- GRALISE ORAL TABLET 300 MG

ST Criteria	Trial of 1 month of gabapentin
QL Criteria	5 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise Starter

Products Affected

- GRALISE STARTER

ST Criteria	Trial of 1 month of gabapentin
QL Criteria	1 pack Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Granisetron HCl

Products Affected

- *granisetron hcl oral*

QL Criteria	10 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Granisol

Products Affected

- GRANISOL

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

Harvoni

Products Affected

- HARVONI

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

Heather

Products Affected

- HEATHER

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

Hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	Non-24 hour sleep-wake cycle
Exclusion Criteria	
Required Medical Information	A documented diagnosis of non-24 sleep-wake disorder AND Member is documented to be totally blind and has no light perception AND Member has a history of at least 3 months of difficulty initiating sleep, difficulty awakening in the morning, or excessive daytime sleepiness AND Member has no other concomitant sleep disorder, i.e., sleep apnea, insomnia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hycamtin

Products Affected

- HYCAMTIN ORAL

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

Hydroxychloroquine Sulfate

Products Affected

- *hydroxychloroquine sulfate oral*

PA Criteria	Criteria Details
Covered Uses	Malaria Rheumatoid arthritis Systemic lupus erythematosus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: malaria rheumatoid arthritis systemic lupus erythematosus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	
QL Criteria	30 days minimum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hysingla ER

Products Affected

- HYSINGLA ER

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hyzaar

Products Affected

- HYZAAR ORAL TABLET 100-25 MG, 100-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hyzaar

Products Affected

- HYZAAR ORAL TABLET 50-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of one of the following: Treatment of bone metastases or bone pain presumed due to bone metastases from breast cancer Treatment of hypercalcemia of malignancy Treatment of osteoporosis in post-menopausal women who are unable to tolerate either 2 oral bisphosphonates (e.g., alendronate (Fosamax), risedronate (Actonel)) or 1 oral bisphosphonate plus 1 selective estrogen receptor modulator (SERM) (e.g., raloxifene (Evista)), or for whom oral bisphosphonate therapy is contraindicated (e.g., due to inability to swallow, or inability to remain in an upright position after oral bisphosphonate administration for the required length of time)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ibrance

Products Affected

- IBRANCE

QL Criteria	21 capsules Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Iclusig

Products Affected

- ICLUSIG

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

Ilevro

Products Affected

- ILEVRO

QL Criteria	15 pen Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imbruvica

Products Affected

- IMBRUVICA

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

Imiquimod

Products Affected

- *imiquimod external*

QL Criteria	120 max day supply Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imitrex

Products Affected

- IMITREX ORAL

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

Imitrex

Products Affected

- IMITREX NASAL

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

Imitrex

Products Affected

- IMITREX SUBCUTANEOUS*

QL Criteria	10 vial Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imitrex STATdose System

Products Affected

- IMITREX STATDOSE SYSTEM

QL Criteria	10 cartridges Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Implanon

Products Affected

- IMPLANON

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

Incivek

Products Affected

- INCIVEK

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

Incruse Ellipta

Products Affected

- INCRUSE ELLIPTA

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

Inderal XL

Products Affected

- INDERAL XL

PA Criteria	Criteria Details
Covered Uses	Hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, propanolol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of generic: propanolol
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Inlyta

Products Affected

- INLYTA

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

Intermezzo

Products Affected

- INTERMEZZO

PA Criteria	Criteria Details
Covered Uses	Insomnia
Exclusion Criteria	
Required Medical Information	For Intermezzo 1.75 mg - (for males or females) A documented diagnosis of treatment of insomnia when middle-of-the-night awakening is followed by difficulty returning to sleep For Intermezzo 3.5mg ? (for males only) A documented diagnosis of treatment of insomnia when middle of the night awakening is followed by difficulty returning to sleep AND ALL of the following: Member is male Member is less than or equal to 65 years of old It is documented they will NOT be taking Intermezzo concomitantly with other CNS depressants (e.g. benzodiazepines, opioids, tricyclic antidepressants, alcohol)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Introvale

Products Affected

- INTROVALE

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

Intuniv

Products Affected

- INTUNIV

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA-diagnosis required for members greater than 18 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days each of 3 of: clonidine/ sr, guanfacine, amphetam/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, or Vyvanse
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED RELEASE 24 HR* 1.5 MG, 3 MG, 6 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Invega

Products Affected

- INVEGA ORAL TABLET EXTENDED RELEASE 24 HR* 9 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Invokamet

Products Affected

- INVOKAMET ORAL TABLET 150-500 MG, 150-1000 MG

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

Invokamet

Products Affected

- INVOKAMET ORAL TABLET 50-500 MG, 50-1000 MG

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

Invokana

Products Affected

- INVOKANA

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

Iprivask

Products Affected

- IPRIVASK

PA Criteria	Criteria Details
Covered Uses	prophylaxis of deep vein thrombosis, which may lead to pulmonary embolism, in patients undergoing elective hip replacement surgery
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Irbesartan

Products Affected

- *irbesartan oral tablet 150 mg, 75 mg*

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

Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg*

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

Irenka

Products Affected

- IRENKA

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

Iressa

Products Affected

- IRESSA

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

Itraconazole

Products Affected

- *itraconazole oral*

PA Criteria	Criteria Details
Covered Uses	Aspergillosis, Invasive, salvage therapy Blastomycosis Candidiasis of the esophagus Histoplasmosis, Disseminated Onychomycosis due to dermatophyte Oropharyngeal candidiasis Pulmonary histoplasmosis
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	A documented diagnosis of one of the below indications and specified criteria AND A documented contraindication/intolerance/allergy/failure of an adequate trial of generic itraconazole (if request is for brand Sporanox) Aspergillosis Blastomycosis Treatment of oropharyngeal/esophageal candidiasis in HIV-infected persons Chromoblastomycosis Coccidioidomycosis associated with AIDS, treatment and prophylaxis Cryptococcosis Cryptococcal meningitis - HIV infection Cutaneous dermatophyte infection: NOTE: tinea pedis/manuum (athletes foot/hand), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor] AND A documented contraindication/intolerance/allergy/failure of an adequate trial of one topical antifungal AND preferred generic oral terbinafine Febrile neutropenia Histoplasmosis Penicillium marneffei infection Prophylaxis of invasive fungal infections in persons with Chronic Granulomatous Disease, hematologic malignancies or liver transplants Disseminated microsporidiosis caused by Trachipleistophora or Brachiola species in HIV-infected persons Onychomycosis (Tinea unguium) due to dermatophyte AND A documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection) AND A documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of preferred generic terbinafine OR any of the following: Presence of hepatic dysfunction or increased risk for liver disease Fungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection) Paracoccidioidomycosis Sporotrichosis Tinea versicolor Tinea capitis AND A documented contraindication/intolerance/allergy/failure of two weeks of generic terbinafine Vulvovaginal Candidiasis
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jakafi

Products Affected

- JAKAFI

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

Jalyn

Products Affected

- JALYN

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member is NOT pregnant AND Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet

Products Affected

- JANUMET

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

Janumet XR

Products Affected

- JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HR* 50-1000 MG

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

Janumet XR

Products Affected

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

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

Januvia

Products Affected

- JANUVIA

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

Jardiance

Products Affected

- JARDIANCE

ST Criteria	Trial of one month of Invokana (single entity or combination)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jencycla

Products Affected

- JENCYCLA

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

Jentadueto

Products Affected

- JENTADUETO

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Januvia OR Onglyza (single entity or combination)
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jolessa

Products Affected

- JOLESSA

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

Jolivette

Products Affected

- JOLIVETTE

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

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 (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections: 12 weeks for toe nailinfections): fluconazole (6 months): griseofulvin (6 months): itraconazole (60 days (PulsePak) for fingernail infections: 90 days for toenail) OR Presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR Member is female and is pregnant and/or breastfeeding AND Member is NOT receiving a systemic (oral) antifungal agent ? terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Junel 1.5/30

Products Affected

- JUNEL 1.5/30

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

Junel 1/20

Products Affected

- JUNEL 1/20

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

Junel FE 1.5/30

Products Affected

- JUNEL FE 1.5/30

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

Junel FE 1/20

Products Affected

- JUNEL FE 1/20

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

Juxtapid

Products Affected

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

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

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG

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

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 20 MG

QL Criteria	84 capsules Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 5 MG

QL Criteria	14 capsules Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kadian

Products Affected

- KADIAN

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kalydeco

Products Affected

- KALYDECO

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

Kalydeco

Products Affected

- KALYDECO

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

Kapvay

Products Affected

- KAPVAY ORAL TABLET EXTENDED RELEASE 12 HR*

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA-diagnosis required for members greater than 18 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days each of 3 of: clonidine/ sr, guanfacine, amphetam/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, or Vyvanse
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Karbinal ER

Products Affected

- KARBINAL ER

ST Criteria	Trial of one week each of a non-sedating OTC antihistamine (i.e., Claritin, Zyrtec) AND generic carbinoxamine
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kariva

Products Affected

- KARIVA

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

Kazano

Products Affected

- KAZANO

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Januvia OR Onglyza (single entity or combination)
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kelnor 1/35

Products Affected

- KELNOR 1/35

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

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR* 500 MG

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

Keppra XR

Products Affected

- KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR* 750 MG

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

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine ophthalmic*

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

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

QL Criteria	20 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Keveyis

Products Affected

- KEVEYIS

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

Khedezla

Products Affected

- KHEDEZLA

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kombiglyze XR

Products Affected

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

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

Kombiglyze XR

Products Affected

- KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HR* 2.5-1000 MG

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

Korlym

Products Affected

- KORLYM

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

Kurvelo

Products Affected

- KURVELO

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG

ST Criteria	Documented trial and failure of 1 month of lamotrigine or lamotrigine ER
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 25 MG

ST Criteria	Documented trial and failure of 1 month of lamotrigine or lamotrigine ER
QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 50 MG

ST Criteria	Documented trial and failure of 1 month of lamotrigine or lamotrigine ER
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL KIT

ST Criteria	Documented trial and failure of 1 month of lamotrigine or lamotrigine ER
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 50 MG, 100 MG, 25 MG

ST Criteria	Documented trial and failure of 1 month of lamotrigine
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL KIT

ST Criteria	Documented trial and failure of 1 month of lamotrigine
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 200 MG

ST Criteria	Documented trial and failure of 1 month of lamotrigine
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LaMICtal XR

Products Affected

- LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 250 MG, 300 MG

ST Criteria	Documented trial and failure of 1 month of lamotrigine
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamISIL

Products Affected

- LAMISIL

PA Criteria	Criteria Details
Covered Uses	Cutaneous leishmaniasis Cutaneous sporotrichosis Paracoccidioidomycosis Seborrheic dermatitis Tinea capitis Onychomycosis (Tinea unguium)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the below indications and specified criteria AND A documented contraindication or intolerance or allergy or failure of an adequate trial of preferred generic terbinafine (if request is for brand Lamisil) Chromoblastomycosis Cutaneous dermatophyte infection: NOTE: tinea pedis/manuum(athletes foot/hand), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor] AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one topical antifungal Cutaneous leishmaniasis Cutaneous sporotrichosis Paracoccidioidomycosis Seborrheic dermatitis Tinea capitis Onychomycosis (Tinea unguium) due to dermatophyte AND A documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

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

LamoTRIgine

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

ST Criteria	Documented trial and failure of 1 month of lamotrigine
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine ER

Products Affected

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

ST Criteria	Documented trial and failure of 1 month of lamotrigine
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine ER

Products Affected

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

ST Criteria	Documented trial and failure of 1 month of lamotrigine
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release 30 mg*

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

Lantus

Products Affected

- LANTUS

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	Only for Fully-Insured Plans: A documented diagnosis of type I or type II diabetes AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred alternative, Levemir
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lantus SoloStar

Products Affected

- LANTUS SOLOSTAR

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	Only for Fully-Insured Plans: A documented diagnosis of type I or type II diabetes AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred alternative, Levemir
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Larin 1/20

Products Affected

- LARIN 1/20

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

Larin Fe 1.5/30

Products Affected

- LARIN FE 1.5/30

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

Larin Fe 1/20

Products Affected

- LARIN FE 1/20

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

Latanoprost

Products Affected

- *latanoprost ophthalmic*

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

Latuda

Products Affected

- LATUDA ORAL TABLET 120 MG, 60 MG, 20 MG, 40 MG

ST Criteria	Trial of 1 month of ONE atypical generic antipsychotic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Latuda

Products Affected

- LATUDA ORAL TABLET 80 MG

ST Criteria	Trial of 1 month of ONE atypical generic antipsychotic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lazanda

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

ST Criteria	Trial of one week of generic alternative: fentanyl transmucosal lozenge
QL Criteria	4 bottle Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Leena

Products Affected

- LEENA

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

Lemtrada

Products Affected

- LEMTRADA

QL Criteria	5 vials Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lenvima 10 MG Daily Dose

Products Affected

- LENVIMA 10 MG DAILY DOSE

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

Lenvima 14 MG Daily Dose

Products Affected

- LENVIMA 14 MG DAILY DOSE

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

Lenvima 20 MG Daily Dose

Products Affected

- LENVIMA 20 MG DAILY DOSE

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

Lenvima 24 MG Daily Dose

Products Affected

- LENVIMA 24 MG DAILY DOSE

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

Lescol

Products Affected

- LESCOL

ST Criteria	1 month trial of ONE generic fluvastatin, lovastatin, pravastatin, simvastatin, OR atorvastatin AND Crestor
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lescol XL

Products Affected

- LESCOL XL

ST Criteria	1 month trial of ONE generic fluvastatin, lovastatin, pravastatin, simvastatin, OR atorvastatin AND Crestor
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lessina

Products Affected

- LESSINA

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

Levaquin

Products Affected

- LEVAQUIN ORAL

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LevETIRAcetam ER

Products Affected

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

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

LevETIRAcetam ER

Products Affected

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

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

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride oral tablet*

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride oral solution*

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	10 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levofloxacin

Products Affected

- *levofloxacin ophthalmic*
- *levofloxacin oral*

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levonest

Products Affected

- LEVONEST

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

Levonorgest-Eth Estrad 91-Day

Products Affected

- *levonorgest-eth estrad 91-day oral tablet*
  0.1-0.02 & 0.01 mg, 0.15-0.03 mg

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

Levonorgestrel

Products Affected

- *levonorgestrel oral tablet 0.75 mg*

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

Levonorgestrel-Ethinyl Estrad

Products Affected

- *levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg*

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

Levonorgestrel-Ethinyl Estrad

Products Affected

- *levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg*

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

Levora 0.15/30 (28)

Products Affected

- LEVORA 0.15/30 (28)

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

Lexapro

Products Affected

- LEXAPRO ORAL SOLUTION

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

Lexapro

Products Affected

- LEXAPRO ORAL TABLET

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

Lialda

Products Affected

- LIALDA

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

Lidoderm

Products Affected

- LIDODERM

PA Criteria	Criteria Details
Covered Uses	Pain associated with post-herpetic neuralgia
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Linzess

Products Affected

- LINZESS

ST Criteria	Trial of one month of lactulose or Miralax AND Amitiza
QL Criteria	1 capsule Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lipitor

Products Affected

- LIPITOR

ST Criteria	1 month trial of ONE generic fluvastatin, lovastatin, pravastatin, simvastatin, OR atorvastatin AND Crestor
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lipofen

Products Affected

- LIPOFEN

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liptruzet

Products Affected

- LIPTRUZET

ST Criteria	1 month trial of ONE generic fluvastatin, lovastatin, pravastatin, simvastatin, OR atorvastatin AND Crestor
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Livalo

Products Affected

- LIVALO

ST Criteria	1 month trial of ONE generic fluvastatin, lovastatin, pravastatin, simvastatin, OR atorvastatin AND Crestor
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Locoid

Products Affected

- LOCOID

ST Criteria	Trial of two weeks of one generic: - betamethasone benzoate, betamethasone dipropionate, betamethasone valerate, desonide lotion, desonide, desoximetasone, fluocinolone acetonide, fluticasone fluocinonide, hydrocortisone butyrate, hydrocortisone valerate, prednicarbate, OR triamcinolone acetonide
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Locoid Lipocream

Products Affected

- LOCOID LIPOCREAM

ST Criteria	Trial of two weeks of one generic: - betamethasone benzoate, betamethasone dipropionate, betamethasone valerate, desonide lotion, desonide, desoximetasone, fluocinolone acetonide, fluticasone fluocinonide, hydrocortisone butyrate, hydrocortisone valerate, prednicarbate, OR triamcinolone acetonide
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lofibra

Products Affected

- LOFIBRA

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lonsurf

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG

QL Criteria	100 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lonsurf

Products Affected

- LONSURF ORAL TABLET 20-8.19 MG

QL Criteria	80 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lopid

Products Affected

- LOPID

ST Criteria	Trial of one month each of the following preferred generic alternatives, gemfibrozil AND any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Loryna

Products Affected

- LORYNA

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

Losartan Potassium

Products Affected

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

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

Losartan Potassium-HCTZ

Products Affected

- *losartan potassium-hctz oral tablet 50-12.5 mg*

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

LoSeasonique

Products Affected

- LOSEASONIQUE

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

Lotrel

Products Affected

- LOTREL

ST Criteria	Trial of one month of the generic equivalent amlodipine/benazepril
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lotronex

Products Affected

- LOTRONEX

PA Criteria	Criteria Details
Covered Uses	Irritable bowel syndrome
Exclusion Criteria	
Required Medical Information	Diagnosis of severe** irritable bowel syndrome (IBS) with primary symptom of diarrhea with: chronic IBS symptoms (generally lasting 6 months or longer) AND anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded AND failure of response to at least one conventional therapy agent for at least one month **Diarrhea-predominant IBS is severe if it includes diarrhea and one or more of the following: (1) frequent and severe abdominal pain/discomfort: or (2) frequent urgency or fecal incontinence: or (3) disability or restriction of daily activities due to IBS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Female
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lovastatin

Products Affected

- *lovastatin*

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

Lovaza

Products Affected

- LOVAZA

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

Lovenox

Products Affected

- LOVENOX

PA Criteria	Criteria Details
Covered Uses	For coverage of additional quantities over 21 day supply: 1. Perioperative management of oral anticoagulation when an invasive procedure is required based on risk 2. Prevention of VTE in patients undergoing cancer surgery and greater than 60 years of age OR who have previously experienced a VTE 3. Orthopaedic procedures, i.e. Elective hip arthroplasty or fracture repair, elective knee arthroplasty, knee arthroscopy in a high risk patient, elective spine surgery in a high risk patient 4. Treatment of VTE, PE, Superficial thrombophlebitis 5. Pregnancy 6. Neonates with VTE or children greater than 2 months of age experiencing idiopathic or secondary thromboembolism 7. Acute ST-elevated MI 8. Cancer 9. Long Distance Travel 10. Heparin Induced Thrombocytopenia (HIT) (Arixtra only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 syringes Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Low-Ogestrel

Products Affected

- LOW-OGESTREL

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

Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION 0.01 %

PA Criteria	Criteria Details
Covered Uses	glaucoma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 week of latanoprost AND 1 week of Travatan Z
QL Criteria	3 ML Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lunesta

Products Affected

- LUNESTA

PA Criteria	Criteria Details
Covered Uses	Insomnia, in members over age 18
Exclusion Criteria	
Required Medical Information	
Age Restrictions	not covered less than 18 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month of a generic hypnotic (i.e., zolpidem, temazepam, triazolam)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lutera

Products Affected

- LUTERA

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

Luvox CR

Products Affected

- LUVOX CR

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

Luxiq

Products Affected

- LUXIQ

ST Criteria	trial of two weeks of generic betamethasone alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lynparza

Products Affected

- LYNPARZA

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

Lysteda

Products Affected

- LYSTEDA

ST Criteria	Trial of one month of the generic tranex acid
QL Criteria	30 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lyza

Products Affected

- LYZA

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

Makena

Products Affected

- MAKENA

QL Criteria	5 vial Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Malarone

Products Affected

- MALARONE

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Malaria medications are Certificate of Cover age (COC) Excluded for travel prophylaxis.
Required Medical Information	A documented diagnosis of malaria
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Marlissa

Products Affected

- *marlissa*

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

Maxalt

Products Affected

- MAXALT

QL Criteria	12 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Maxalt-MLT

Products Affected

- MAXALT-MLT

QL Criteria	12 blisters Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Maxitrol

Products Affected

- MAXITROL OPHTHALMIC SUSPENSION

QL Criteria	15 pen Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

MedroxyPROGESTERone Acetate

Products Affected

- *medroxyprogesterone acetate intramuscular**

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

Mefloquine HCl

Products Affected

- *mefloquine hcl*

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Malaria medications are Certificate of Cover age (COC) Excluded for travel prophylaxis.
Required Medical Information	A documented diagnosis of malaria
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mekinist

Products Affected

- MEKINIST

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

Menostar

Products Affected

- MENOSTAR

QL Criteria	1 patch Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metadate CD

Products Affected

- METADATE CD

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metadate ER

Products Affected

- METADATE ER

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	3 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadone HCl

Products Affected

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

QL Criteria	180 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methadose

Products Affected

- METHADOSE ORAL TABLET SOLUBLE
- METHADOSE ORAL TABLET

QL Criteria	180 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methamphetamine HCl

Products Affected

- *methamphetamine hcl*

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

Methylin

Products Affected

- METHYLIN ORAL SOLUTION 10 MG/5ML

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	30 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylin

Products Affected

- METHYLIN ORAL SOLUTION 5 MG/5ML

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	60 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylin

Products Affected

- METHYLIN ORAL TABLET CHEWABLE

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	6 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet chewable*

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extendedrelease* 36 mg*

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extendedrelease* 20 mg*

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

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

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

Methylphenidate HCl ER (LA)

Products Affected

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

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

Methylphenidate HCl ER (LA)

Products Affected

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

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

Mevacor

Products Affected

- MEVACOR

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

Miacalcin

Products Affected

- MIACALCIN INJECTION

PA Criteria	Criteria Details
Covered Uses	Hypercalcemia Paget's disease Postmenopausal osteoporosis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypercalcemia Individuals who present with an osteoporotic spinal compression fracture on imaging with correlating clinical signs and symptoms suggesting an acute injury (0 to 5 days after identifiable event or onset of symptoms) and who are neurologically intact. (Note: Calcitonin treatment is considered medically necessary for 4 weeks for this indication). Paget?s disease of bone (osteitis deformans) Treatment of Osteoporosis in postmenopausal women AND documentation of any of the following: Unable to tolerate two oral bisphosphonates (e.g., alendronate (Fosamax), risedronate (Actonel), or one oral bisphosphonate plus one selective estrogen receptor modulator (SERM) (e.g., raloxifene (Evista) Oral bisphosphonate therapy is contraindicated (e.g., due to inability to swallow, or inability to remain in an upright position after oral bisphosphonate administration for the required length of time).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Miacalcin

Products Affected

- MIACALCIN NASAL

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

Microgestin 1.5/30

Products Affected

- MICROGESTIN 1.5/30

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

Microgestin 1/20

Products Affected

- MICROGESTIN 1/20

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

Microgestin FE 1.5/30

Products Affected

- MICROGESTIN FE 1.5/30

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

Microgestin FE 1/20

Products Affected

- MICROGESTIN FE 1/20

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

Migranal

Products Affected

- MIGRANAL

ST Criteria	Trial of the preferred generic equivalent, dihydroergotamine nasal spray AND three of the following preferred generic alternatives for the treatment of 2 migraine episodes: naratriptan rizatriptan/ mlt sumatriptan zolmitriptan/ odt
QL Criteria	1 box Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mimvey

Products Affected

- MIMVEY

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

Minivelle

Products Affected

- MINIVELLE

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

Minocin

Products Affected

- MINOCIN ORAL CAPSULE 100 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	For Adoxa, Dynacin, Minocin and Monodox Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age) AND ONE of the following: 1) A documented diagnosis of acne or rosacea, OR: 2) A documented diagnosis of infection other than acne or rosacea
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
ST Criteria	Trial of three days of: doxycycline (for Acticlate, Adoxa, Oraxyl or Monodox) or minocycline (for Dynacin or Minocin)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Minocycline HCl

Products Affected

- *minocycline hcl oral*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Minocycline HCl ER

Products Affected

- *minocycline hcl er*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mirapex ER

Products Affected

- MIRAPEX ER

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

Mirena

Products Affected

- MIRENA

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

Mirtazapine

Products Affected

- *mirtazapine oral tablet 30 mg, 15 mg, 45 mg*
- *mirtazapine oral tablet dispersible*

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

Mirvaso

Products Affected

- MIRVASO

ST Criteria	Trial of one month each of any of the preferred topical generic alternatives, metronidazole and sulfacetamide sodium with sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mitigare

Products Affected

- MITIGARE

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

Modafinil

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsyExcessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
Exclusion Criteria	
Required Medical Information	For narcolepsy:A. 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, andB. A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, andC. The patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, andD. CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, andE. The daytime fatigue is significantly impacting, impairing, or compromising the patient?s ability to function normally, andF. The prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, andG. Patients must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Monodox

Products Affected

- MONODOX ORAL CAPSULE 75 MG, 100 MG

PA Criteria	Criteria Details
Covered Uses	For Adoxa, Dynacin, Minocin and Monodox Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age) AND ONE of the following: 1) A documented diagnosis of acne or rosacea, OR: 2) A documented diagnosis of infection other than acne or rosacea
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
ST Criteria	Trial of three days of: doxycycline (for Acticlate, Adoxa, Oraxyl or Monodox) or minocycline (for Dynacin or Minocin)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mono-Linyah

Products Affected

- MONO-LINYAH

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

MonoNessa

Products Affected

- MONONESSA

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Morphine Sulfate ER

Products Affected

- *morphine sulfate er oral tablet extendedrelease**

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

Morphine Sulfate ER

Products Affected

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

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

Movantik

Products Affected

- MOVANTIK

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Opioid induced constipation in patients with non-cancer pain
Exclusion Criteria	
Required Medical Information	Patient must have been receiving treatment with opioid narcotics for at least 4 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Moxeza

Products Affected

- MOXEZA

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

Myorisan

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring ANDMember is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria:1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has received a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
ST Criteria	Trial of 1 generic oral antibiotic prescribed for the treatment of acne (i.e., minocycline or doxycycline)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myrbetriq

Products Affected

- MYRBETRIQ

ST Criteria	Trial of 1 month of trospium/er OR tolteridine/er
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myzilra

Products Affected

- MYZILRA

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

Naratriptan HCl

Products Affected

- *naratriptan hcl*

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

Natacyn

Products Affected

- NATACYN

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

Natesto

Products Affected

- NATESTO

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	3 pumps Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Natpara

Products Affected

- NATPARA

QL Criteria	2 cartridges Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Necon 0.5/35 (28)

Products Affected

- NECON 0.5/35 (28)

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

Necon 1/35 (28)

Products Affected

- NECON 1/35 (28)

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

Necon 10/11 (28)

Products Affected

- NECON 10/11 (28)

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

Necon 7/7/7

Products Affected

- NECON 7/7/7

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

Nefazodone HCl

Products Affected

- *nefazodone hcl oral tablet 50 mg, 250 mg*

ST Criteria	Trial of one month of one: budeprion SR/XL bupropion/SR/XL citalopram escitalopram fluoxetine fluvoxamine paroxetine/sr mirtazapine selfemra sertraline venlafaxine venlafaxine er tablet venlafaxine sr cap
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neomycin-Polymyxin-Dexameth

Products Affected

- *neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1*

QL Criteria	15 pen Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neomycin-Polymyxin-Gramicidin

Products Affected

- *neomycin-polymyxin-gramicidin*

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

Neomycin-Polymyxin-HC

Products Affected

- *neomycin-polymyxin-hc otic solution 3.5-10000-1*

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

Neomycin-Polymyxin-HC

Products Affected

- *neomycin-polymyxin-hc otic suspension*

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

Neosporin

Products Affected

- NEOSPORIN

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

Nesina

Products Affected

- NESINA

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Januvia OR Onglyza (single entity or combination)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupro

Products Affected

- NEUPRO

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

Neurontin

Products Affected

- NEURONTIN ORAL CAPSULE

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

Neurontin

Products Affected

- NEURONTIN ORAL TABLET

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

Nevanac

Products Affected

- NEVANAC

QL Criteria	15 pen Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexAVAR

Products Affected

- NEXAVAR

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

NexIUM

Products Affected

- NEXIUM ORAL PACKET

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

NexIUM

Products Affected

- NEXIUM ORAL CAPSULE DELAYED RELEASE 40 MG

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

Nexplanon

Products Affected

- NEXPLANON

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

Next Choice

Products Affected

- NEXT CHOICE

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

Next Choice One Dose

Products Affected

- NEXT CHOICE ONE DOSE

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

Nicotine

Products Affected

- *nicotine transdermal patch 24 hr*

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

Nora-BE

Products Affected

- NORA-BE

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

Norethindrone

Products Affected

- *norethindrone oral*

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

Norethindrone-Eth Estradiol

Products Affected

- *norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg*

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

Norgestimate-Eth Estradiol

Products Affected

- *norgestimate-eth estradiol*

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

Norgestim-Eth Estrad Triphasic

Products Affected

- *norgestim-eth estrad triphasic*

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

Norgestrel-Ethinyl Estradiol

Products Affected

- *norgestrel-ethinyl estradiol*

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

Noroxin

Products Affected

- NOROXIN

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Northera

Products Affected

- NORTHERA ORAL CAPSULE 100 MG

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

Northera

Products Affected

- NORTHERA ORAL CAPSULE 200 MG, 300 MG

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

Nortrel 0.5/35 (28)

Products Affected

- NORTREL 0.5/35 (28)

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

Nortrel 1/35 (21)

Products Affected

- NORTREL 1/35 (21)

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

Nortrel 1/35 (28)

Products Affected

- NORTREL 1/35 (28)

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

Nortrel 7/7/7

Products Affected

- NORTREL 7/7/7

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

Norvasc

Products Affected

- NORVASC

ST Criteria	Trial of one month of the preferred generic equivalent, amlodipine
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG

Products Affected

- NOVOLOG

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of the preferred alternative Humalog product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG FlexPen

Products Affected

- NOVOLOG FLEXPEN

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of the preferred alternative Humalog product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG Mix 70/30

Products Affected

- NOVOLOG MIX 70/30

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of the preferred alternative Humalog product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG Mix 70/30 FlexPen

Products Affected

- NOVOLOG MIX 70/30 FLEXPEN

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of the preferred alternative Humalog product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucynta

Products Affected

- NUCYNTA

ST Criteria	Trial of 2 days of immediate release oxycodone, hydromorphone, or morphine
QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucynta ER

Products Affected

- NUCYNTA ER

PA Criteria	Criteria Details
Covered Uses	Chronic pain due to malignant condition or severe pain requiring daily, around the clock, long term opioid treatment Diabetic peripheral neuropathy
Exclusion Criteria	
Required Medical Information	For chronic pain: Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuedexta

Products Affected

- NUEDEXTA

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

NuvaRing

Products Affected

- NUVARING

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

Nuvigil

Products Affected

- NUVIGIL ORAL TABLET 200 MG

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsyExcessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
Exclusion Criteria	
Required Medical Information	For narcolepsy:A. 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, andB. A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, andC. The patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, andD. CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, andE. The daytime fatigue is significantly impacting, impairing, or compromising the patient?s ability to function normally, andF. The prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, andG. Patients must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuvigil

Products Affected

- NUVIGIL ORAL TABLET 50 MG

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsyExcessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
Exclusion Criteria	
Required Medical Information	For narcolepsy:A. 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, andB. A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, andC. The patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, andD. CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, andE. The daytime fatigue is significantly impacting, impairing, or compromising the patient?s ability to function normally, andF. The prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, andG. Patients must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuvigil

Products Affected

- NUVIGIL ORAL TABLET 150 MG, 250 MG

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsyExcessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
Exclusion Criteria	
Required Medical Information	For narcolepsy:A. 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, andB. A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, andC. The patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, andD. CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, andE. The daytime fatigue is significantly impacting, impairing, or compromising the patient?s ability to function normally, andF. The prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, andG. Patients must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nymalize

Products Affected

- NYMALIZE

QL Criteria	2520 ml Per 21 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ocella

Products Affected

- OCELLA

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

Ocufen

Products Affected

- OCUFEN

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

Ocuflox

Products Affected

- OCUFLOX

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

Odomzo

Products Affected

- ODOMZO

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

Ofev

Products Affected

- OFEV

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

Ofloxacin

Products Affected

- *ofloxacin ophthalmic*

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
QL Criteria	1 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ofloxacin

Products Affected

- *ofloxacin otic*

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
QL Criteria	2 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ofloxacin

Products Affected

- *ofloxacin oral*

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, OR A documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, OR A documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, OR Member needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), OR A documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA APPLIES TO MEMBERS less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OLANZapine

Products Affected

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

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

OLANZapine

Products Affected

- *olanzapine oral tablet 2.5 mg*

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

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl*

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

Olux

Products Affected

- OLUX

ST Criteria	Trial of two weeks of generic clobetasol alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Olux-E

Products Affected

- OLUX-E

ST Criteria	Trial of two weeks of generic clobetasol alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Olysio

Products Affected

- OLYSIO

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

Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

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

Omeprazole

Products Affected

- *omeprazole oral capsule delayed release*

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

Omeprazole-Sodium Bicarbonate

Products Affected

- *omeprazole-sodium bicarbonate oral capsule 40-1100 mg*

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

Omniflex Diaphragm

Products Affected

- OMNIFLEX DIAPHRAGM

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

Ondansetron

Products Affected

- *ondansetron*

QL Criteria	12 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron

Products Affected

- *ondansetron*

QL Criteria	12 tablets Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 24 mg*

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

Ondansetron HCl

Products Affected

- *ondansetron hcl oral solution*

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

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 4 mg, 8 mg*

QL Criteria	12 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onexton

Products Affected

- ONEXTON

ST Criteria	Trial of one month of generic alternative: benzoyl peroxide/ clindamycin phosphate gel OR benzoyl peroxide/ erythromycin gel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onfi

Products Affected

- ONFI ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory?(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities for those members who meet the following criterion: 1) Patient?s dose is being titrated by the physician OR does the patient require higher doses of the requested drug after failure of recommended standard doses.
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onfi

Products Affected

- ONFI ORAL TABLET 20 MG, 10 MG

PA Criteria	Criteria Details
Covered Uses	Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	A documented diagnosis of seizures associated with Lennox-Gastaut syndrome or refractory?(therapy resistant) epilepsy AND Concomitant use of an anticonvulsant drug
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities for those members who meet the following criterion: 1) Patient?s dose is being titrated by the physician OR does the patient require higher doses of the requested drug after failure of recommended standard doses.
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onglyza

Products Affected

- ONGLYZA

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

Onmel

Products Affected

- ONMEL

PA Criteria	Criteria Details
Covered Uses	onychomycosis (Tinea unguium)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of onychomycosis (Tinea unguium) due to dermatophyte AND A documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of 6 weeks of preferred generic terbinafine OR any of the following: Presence of hepatic dysfunction or increased risk for liver disease Fungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of 6 weeks of the preferred generic, itraconazole
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opana ER

Products Affected

- OPANA ER ORAL

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

Opsumit

Products Affected

- OPSUMIT

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

Oracea

Products Affected

- ORACEA

PA Criteria	Criteria Details
Covered Uses	Rosacea
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Rosacea, AND Age greater than 8 years old, AND A documented contraindication or intolerance or allergy or failure of an adequate trial of fourteen days of the preferred alternative topical metronidazole OR generic doxycycline
Age Restrictions	greater than 8 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oravig

Products Affected

- ORAVIG

QL Criteria	14 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orkambi

Products Affected

- ORKAMBI

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

Orsythia

Products Affected

- ORSYTHIA

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

Ortho Diaphragm Coil

Products Affected

- ORTHO DIAPHRAGM COIL

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

Ortho Diaphragm Flat

Products Affected

- ORTHO DIAPHRAGM FLAT

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

Oseni

Products Affected

- OSENI

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of pioglitazone in combination with one preferred alternative: Januvia or Onglyza (single entity or combination)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxtellar XR

Products Affected

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

ST Criteria	trial of one month of the preferred generic alternative, oxcarbazepine
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 600 MG

ST Criteria	trial of one month of the preferred generic alternative, oxcarbazepine
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl ER

Products Affected

- *oxycodone hcl er*

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

Oxycodone-Ibuprofen

Products Affected

- *oxycodone-ibuprofen*

QL Criteria	28 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCONTIN

Products Affected

- OXYCONTIN

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl ER

Products Affected

- *oxymorphone hcl er*

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

Oxytrol

Products Affected

- OXYTROL

PA Criteria	Criteria Details
Covered Uses	Overactive Bladder (if male)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of trospium/er OR tolteridine/er AND Myrbetriq AND Vesicare
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paliperidone ER

Products Affected

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

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

Paliperidone ER

Products Affected

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

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

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hr* 1.5 mg*

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 10, 2015

Pantoprazole Sodium

Products Affected

- *pantoprazole sodium oral*

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

Paragard Intrauterine Copper

Products Affected

- PARAGARD INTRAUTERINE COPPER

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

PARoxetine HCl

Products Affected

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

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

PARoxetine HCl

Products Affected

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

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er*

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

Patanol

Products Affected

- PATANOL

ST Criteria	Trial of one week of Pataday
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paxil

Products Affected

- PAXIL ORAL TABLET 20 MG, 10 MG

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

Paxil

Products Affected

- PAXIL ORAL SUSPENSION

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

Paxil

Products Affected

- PAXIL ORAL TABLET 30 MG, 40 MG

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

Paxil CR

Products Affected

- PAXIL CR

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

Penlac

Products Affected

- PENLAC

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 (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections: 12 weeks for toe nailinfections): fluconazole (6 months): griseofulvin (6 months): itraconazole (60 days (PulsePak) for fingernail infections: 90 days for toenail) OR Presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR Member is female and is pregnant and/or breastfeeding AND Member is NOT receiving a systemic (oral) antifungal agent ? terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pennsaid

Products Affected

- PENNSAID TRANSDERMAL SOLUTION
  1.5 %

ST Criteria	Trial of one month of Voltaren gel.
QL Criteria	15 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pennsaid

Products Affected

- PENNSAID TRANSDERMAL SOLUTION 2 %

ST Criteria	Trial of one month of Voltaren gel.
QL Criteria	4 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 250 MG

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

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 500 MG

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

Perforomist

Products Affected

- PERFOROMIST

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of Foradil AND Serevent
QL Criteria	60 vials (120ml) Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pertzye

Products Affected

- PERTZYE

ST Criteria	Trial of two weeks of two alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pexeva

Products Affected

- PEXEVA ORAL TABLET 20 MG, 10 MG

ST Criteria	Trial of 1 month of: budeprion sr/ xl, bupropion/ sr/ xl, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine/ sr, mirtazapine, selfemra, sertraline, venlafaxine sr capsule, OR venlafaxine
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pexeva

Products Affected

- PEXEVA ORAL TABLET 30 MG, 40 MG

ST Criteria	Trial of 1 month of: budeprion sr/ xl, bupropion/ sr/ xl, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine/ sr, mirtazapine, selfemra, sertraline, venlafaxine sr capsule, OR venlafaxine
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Philith

Products Affected

- PHILITH

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

Picato

Products Affected

- PICATO

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

Pimtrea

Products Affected

- PIMTREA

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

Pirmella 1/35

Products Affected

- PIRMELLA 1/35

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

Pirmella 7/7/7

Products Affected

- PIRMELLA 7/7/7

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

Plaquenil

Products Affected

- PLAQUENIL

PA Criteria	Criteria Details
Covered Uses	Malaria Rheumatoid arthritis Systemic lupus erythematosus
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: malaria rheumatoid arthritis systemic lupus erythematosus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	
QL Criteria	30 days minimum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plavix

Products Affected

- PLAVIX ORAL TABLET 75 MG

ST Criteria	Trial of one month of GENERIC clopidogrel
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plavix

Products Affected

- PLAVIX ORAL TABLET 300 MG

ST Criteria	Trial of one month of GENERIC clopidogrel
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy

Products Affected

- PLEGRIDY

QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK

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

Plexion

Products Affected

- PLEXION

PA Criteria	Criteria Details
Covered Uses	acne or seborrheic dermatitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne or seborrheic dermatitis AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of two preferred generic sulfacetamide sodium with sulfur products
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of?two preferred generic sulfacetamide sodium with sulfur products
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plexion Cleanser

Products Affected

- PLEXION CLEANSER EXTERNAL LIQUID†

PA Criteria	Criteria Details
Covered Uses	acne or seborrheic dermatitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne or seborrheic dermatitis AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of two preferred generic sulfacetamide sodium with sulfur products
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of?two preferred generic sulfacetamide sodium with sulfur products
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plexion Cleansing Cloth

Products Affected

- PLEXION CLEANSING CLOTH
  EXTERNAL PAD

PA Criteria	Criteria Details
Covered Uses	acne or seborrheic dermatitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne or seborrheic dermatitis AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of two preferred generic sulfacetamide sodium with sulfur products
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of?two preferred generic sulfacetamide sodium with sulfur products
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Polymyxin B-Trimethoprim

Products Affected

- *polymyxin b-trimethoprim*

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

Polytrim

Products Affected

- POLYTRIM

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

Pomalyst

Products Affected

- POMALYST

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

Portia-28

Products Affected

- PORTIA-28

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

Potiga

Products Affected

- POTIGA ORAL TABLET 300 MG, 200 MG, 400 MG

PA Criteria	Criteria Details
Covered Uses	partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND Documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities for those members who meet the following criterion: 1) Patient?s dose is being titrated by the physician OR does the patient require higher doses of the requested drug after failure of recommended standard doses.
QL Criteria	3 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Potiga

Products Affected

- POTIGA ORAL TABLET 50 MG

PA Criteria	Criteria Details
Covered Uses	partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures AND Documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities for those members who meet the following criterion: 1) Patient?s dose is being titrated by the physician OR does the patient require higher doses of the requested drug after failure of recommended standard doses.
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pradaxa

Products Affected

- PRADAXA

ST Criteria	Trial of 1 month each of Eliquis AND Xarelto
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Praluent

Products Affected

- PRALUENT

QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er*

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

Prandin

Products Affected

- PRANDIN

ST Criteria	Trial of one month of generic repaglinide
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pravachol

Products Affected

- PRAVACHOL

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

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

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

Pred-G

Products Affected

- PRED-G

QL Criteria	15 pen Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prefest

Products Affected

- PREFEST

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

Prentif Cavity-Rim Cerv Cap

Products Affected

- PRENTIF CAVITY-RIM CERV CAP

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

Prentif Cavity-Rim Cerv Cap

Products Affected

- PRENTIF CAVITY-RIM CERV CAP

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

Prentif Fitting Set

Products Affected

- PRENTIF FITTING SET

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

Prevacid

Products Affected

- PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prevacid SoluTab

Products Affected

- PREVACID SOLUTAB

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Previfem

Products Affected

- PREVIFEM

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

Prevpac

Products Affected

- PREVPAC

PA Criteria	Criteria Details
Covered Uses	Helicobacter pylori infection Peptic ulcer disease
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Helicobacter pylori infection and peptic ulcer disease (gastric or duodenal ulcer disease) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of two weeks of the preferred generic alternatives, lansoprazole, amoxicillin, and clarithromycin, all taken concomitantly
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of two weeks of generic: lansoprazole, amoxicillin, AND clarithromycin All taken concomitantly
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PriLOSEC

Products Affected

- PRILOSEC ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	2 pack Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PriLOSEC

Products Affected

- PRILOSEC ORAL CAPSULE DELAYED RELEASE

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pristiq

Products Affected

- PRISTIQ

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pristiq

Products Affected

- PRISTIQ

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ProAir HFA

Products Affected

- PROAIR HFA

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

ProAir RespiClick

Products Affected

- PROAIR RESPICLICK

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

ProCentra

Products Affected

- PROCENTRA

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	40 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Procysbi

Products Affected

- PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG

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

Procysbi

Products Affected

- PROCYSBI ORAL CAPSULE DELAYED RELEASE 75 MG

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

Promethazine HCl

Products Affected

- *promethazine hcl suppository 25 mg, 12.5 mg*
- *promethazine hcl oral*

PA Criteria	Criteria Details
Covered Uses	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
Exclusion Criteria	
Required Medical Information	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and Phenergan B AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeine A. Member is less than 2 years of age OR B. Member is less than 6 years of age AND C. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	FDA alert: Use of Phenergan/promethazine is contraindicated in Infants and Children less than 2 years of age, due to risks for fatal respiratory depression. In addition the use of promethazine and codeine (with or without phenylephrine) is contraindicated in pediatric patients less than 6 years of age
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promethazine-Codeine

Products Affected

- *promethazine-codeine*

PA Criteria	Criteria Details
Covered Uses	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
Exclusion Criteria	
Required Medical Information	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and Phenergan B AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeine A. Member is less than 2 years of age OR B. Member is less than 6 years of age AND C. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	FDA alert: Use of Phenergan/promethazine is contraindicated in Infants and Children less than 2 years of age, due to risks for fatal respiratory depression. In addition the use of promethazine and codeine (with or without phenylephrine) is contraindicated in pediatric patients less than 6 years of age
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promethazine-DM

Products Affected

- *promethazine-dm*

PA Criteria	Criteria Details
Covered Uses	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
Exclusion Criteria	
Required Medical Information	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and Phenergan B AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeine A. Member is less than 2 years of age OR B. Member is less than 6 years of age AND C. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	FDA alert: Use of Phenergan/promethazine is contraindicated in Infants and Children less than 2 years of age, due to risks for fatal respiratory depression. In addition the use of promethazine and codeine (with or without phenylephrine) is contraindicated in pediatric patients less than 6 years of age
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Proscar

Products Affected

- PROSCAR

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	(Member is male) Age greater than 50 yrs old OR Member has diagnosis of BPH (Benign Prostatic Hyperplasia) (Member is female) Member is NOT pregnant AND Member has documented diagnosis of hirsutism secondary to ovarian or adrenal dysfunction (for example, polycystic ovary syndrome, adrenal or ovarian tumor) OR Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Protonix

Products Affected

- PROTONIX ORAL

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Protonix

Products Affected

- PROTONIX ORAL

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 pack Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Protopic

Products Affected

- PROTOPIC

PA Criteria	Criteria Details
Covered Uses	atopic dermatitis
Exclusion Criteria	
Required Medical Information	For Protopic 0.1% A documented diagnosis of atopic dermatitis (eczema) in an adult or an adolescent 16 years of age or older, AND one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient?s condition, OR A documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient?s condition, OR Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. For Protopic 0.03% A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months) (Note: requirement of a trial of topical corticosteroid is not required) OR A documented diagnosis of atopic dermatitis (eczema) in an adult or child 2 years of age or older, AND one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient?s condition, OR A documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient?s condition, OR Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas
Age Restrictions	greater than or equal to 16 FOR 0.1%
Prescriber Restrictions	
Coverage Duration	For face, eyelids, genital areas:3 months,All other areas:6 months,Patients under 2 yrs: 3 months
Other Criteria	
Notes/ References	

Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Proventil HFA

Products Affected

- PROVENTIL HFA

PA Criteria	Criteria Details
Covered Uses	Treatment and prevention of bronchospasms
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 week each of Ventolin HFA AND Proair
QL Criteria	2 inhalers Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Provigil

Products Affected

- PROVIGIL

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsyExcessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
Exclusion Criteria	
Required Medical Information	For narcolepsy:A. 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, andB. A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSAHS, andC. The patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, andD. CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, andE. The daytime fatigue is significantly impacting, impairing, or compromising the patient?s ability to function normally, andF. The prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, andG. Patients must be compliant with recommendations for OSAHS treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PROzac

Products Affected

- PROZAC ORAL CAPSULE 20 MG

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

PROzac

Products Affected

- PROZAC ORAL CAPSULE 40 MG

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

PROzac

Products Affected

- PROZAC ORAL CAPSULE 10 MG

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

PROzac Weekly

Products Affected

- PROZAC WEEKLY

QL Criteria	1 caps Per 7 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pulmicort

Products Affected

- PULMICORT

PA Criteria	Criteria Details
Covered Uses	Covered for the maintenance treatment of asthma and as prophylactic therapy in children 1-4 years of age, or in children 5-8 years of age if unable to use metered dose inhalers. Not FDA approved for therapy in children greater than 8
Exclusion Criteria	Budesonide inhalation solution is NOT covered for members with the following criteria:A. Use not approved by the FDA: andB. 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)C. Patient greater than 8 years of ageD. Children 5-8 years of age and able to use metered-dose inhalersE. Use in primary treatment of status asthmaticus or other acute episodes of asthma where intensive measures are required.F. Use in acute bronchospasms
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	8 years of age or younger
Coverage Duration	1 year
Other Criteria	Medical Exception for Pulmicort Respules: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
ST Criteria	For coverage of brand Pulmicort Respules: Trial of generic budesonide inhalation suspension.
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pulmicort Flexhaler

Products Affected

- PULMICORT FLEXHALER

ST Criteria	Trial of 1 month of Asmanex AND Qvar
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl

Products Affected

- QNASL

ST Criteria	Trial of 2 weeks each of 2 of Nasonex, budesonide, flunisolide, fluticasone, OR triamcinolone.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl Childrens

Products Affected

- QNASL CHILDRENS

ST Criteria	Trial of 2 weeks each of 2 of Nasonex, budesonide, flunisolide, fluticasone, OR triamcinolone.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qualaquin

Products Affected

- QUALAQUIN

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Malaria medications are Certificate of Cover age (COC) Excluded for travel prophylaxis.
Required Medical Information	A documented diagnosis of malaria
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
QL Criteria	42 caps Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Quasense

Products Affected

- QUASENSE

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

Qudexy XR

Products Affected

- QUDEXY XR

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

QUEtiapine Fumarate

Products Affected

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

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

QUEtiapine Fumarate

Products Affected

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

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

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

Quillivant XR

Products Affected

- QUILLIVANT XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	12 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

QuiNINE Sulfate

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Malaria medications are Certificate of Cover age (COC) Excluded for travel prophylaxis.
Required Medical Information	A documented diagnosis of malaria
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Maximum Approval for Malaria: 30 days Maximum Approval for all other indications: One year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
QL Criteria	42 caps Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

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

Ranexa

Products Affected

- RANEXA ORAL TABLET EXTENDED RELEASE 12 HR* 1000 MG

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

Ranexa

Products Affected

- RANEXA ORAL TABLET EXTENDED RELEASE 12 HR* 500 MG

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

Rapaflo

Products Affected

- RAPAFLO

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rayos

Products Affected

- RAYOS

ST Criteria	Trial of prednisone
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reclast

Products Affected

- RECLAST

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

Reclipsen

Products Affected

- RECLIPSEN

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

Relenza Diskhaler

Products Affected

- RELENZA DISKHALER

QL Criteria	2 EA Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid-induced constipation, AND 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), AND Member is receiving palliative care, AND Concomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), AND Trial and failure of two (2) laxatives (i.e., docusate sodium, Miralax, bisacodyl, lactulose, senna)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Relistor will be considered medically necessary for those members who meet ANY of the following criteria: Member requires dosing of one vial/syringe every other day (maximum quantity of 15 vials or 2 kits per 30 days).
QL Criteria	1 kit Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS* SOLUTION
  8 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid-induced constipation, AND 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), AND Member is receiving palliative care, AND Concomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), AND Trial and failure of two (2) laxatives (i.e., docusate sodium, Miralax, bisacodyl, lactulose, senna)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Relistor will be considered medically necessary for those members who meet ANY of the following criteria: Member requires dosing of one vial/syringe every other day (maximum quantity of 15 vials or 2 kits per 30 days).
QL Criteria	11 syringe Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS* SOLUTION
  12 MG/0.6ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid-induced constipation, AND 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), AND Member is receiving palliative care, AND Concomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), AND Trial and failure of two (2) laxatives (i.e., docusate sodium, Miralax, bisacodyl, lactulose, senna)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Relistor will be considered medically necessary for those members who meet ANY of the following criteria: Member requires dosing of one vial/syringe every other day (maximum quantity of 15 vials or 2 kits per 30 days).
QL Criteria	10 vial Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relpax

Products Affected

- RELPAX

ST Criteria	Trial of 1 month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
QL Criteria	6 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remeron

Products Affected

- REMERON

ST Criteria	Trial of one month of generic mirtazapine OR mirtazapine ODT
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remeron SolTab

Products Affected

- REMERON SOLTAB

ST Criteria	Trial of one month of generic mirtazapine OR mirtazapine ODT
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repatha

Products Affected

- REPATHA

QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repatha SureClick

Products Affected

- REPATHA SURECLICK

QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Requip XL

Products Affected

- REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR* 8 MG, 6 MG, 4 MG, 2 MG

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

Requip XL

Products Affected

- REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR* 12 MG

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

Rescula

Products Affected

- RESCULA

PA Criteria	Criteria Details
Covered Uses	glaucoma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 week of latanoprost AND 1 week of Travatan Z
QL Criteria	1 bottle Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Retin-A

Products Affected

- RETIN-A

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Tretinoin and one of the following: adapalene, benzoyl peroxide, topical clindamycin, topical erythromycin, sulfacetamide w/sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Retin-A Micro

Products Affected

- RETIN-A MICRO

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Tretinoin and one of the following: adapalene, benzoyl peroxide, topical clindamycin, topical erythromycin, sulfacetamide w/sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Retin-A Micro Pump

Products Affected

- RETIN-A MICRO PUMP EXTERNAL 0.04 %, 0.1 %

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Tretinoin and one of the following: adapalene, benzoyl peroxide, topical clindamycin, topical erythromycin, sulfacetamide w/sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Revatio

Products Affected

- REVATIO ORAL TABLET

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

Revatio

Products Affected

- REVATIO ORAL SUSPENSION RECONSTITUTED

QL Criteria	224 ML Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rexulti

Products Affected

- REXULTI

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

Riax

Products Affected

- RIAX

ST Criteria	Trial of one month of benzoyl peroxide foam
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

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

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

Risedronate Sodium

Products Affected

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

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

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 0.5 MG, 3 MG, 1 MG, 0.25 MG, 2 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- RISPERDAL ORAL SOLUTION

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL

Products Affected

- RISPERDAL ORAL TABLET 4 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	4 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 0.5 MG, 2 MG, 1 MG, 3 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperDAL M-TAB

Products Affected

- RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 4 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	4 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral tablet 3 mg, 2 mg, 0.5 mg, 1 mg, 0.25 mg*
- *risperidone oral tablet dispersible 0.25 mg, 1 mg, 0.5 mg, 2 mg, 3 mg*

ST Criteria	Trial of 1 month of risperidone oral tablet
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

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

ST Criteria	Trial of 1 month of risperidone oral tablet
QL Criteria	4 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral solution*

ST Criteria	Trial of 1 month of risperidone oral tablet
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 4 MG

ST Criteria	Trial of 1 month of risperidone oral tablet
QL Criteria	4 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 2 MG, 0.5 MG, 1 MG, 3 MG

ST Criteria	Trial of 1 month of risperidone oral tablet
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin

Products Affected

- RITALIN

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 40 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 60 MG

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

Ritalin LA

Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 30 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ritalin SR

Products Affected

- RITALIN SR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

QL Criteria	12 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

QL Criteria	12 Blisters Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ROPINIRole HCl ER

Products Affected

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

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

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release 24 hr* 12 mg*

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

Rozerem

Products Affected

- ROZEREM

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	refractory complex partial seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of refractory complex partial seizures AND Documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	6 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	refractory complex partial seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of refractory complex partial seizures AND Documented concurrent therapy with one of the following: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sanctura

Products Affected

- SANCTURA

ST Criteria	Trial of 1 month each of trospium/er OR tolteridine/er AND Myrbetriq AND Vesicare
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sancuso

Products Affected

- SANCUSO

QL Criteria	1 patch Per 21 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saphris

Products Affected

- SAPHRIS

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

Saphris

Products Affected

- SAPHRIS

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savaysa

Products Affected

- SAVAYSA

PA Criteria	Criteria Details
Covered Uses	PENDING
Exclusion Criteria	PENDING
Required Medical Information	PENDING
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	Step Therapy
ST Criteria	Trial of Eliquis AND Xarelto
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella

Products Affected

- SAVELLA

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of 3 of the following drugs/ drug classes: 1 tricyclic antidepressant (i.e., amitriptyline), 1 muscle relaxant (i.e., cyclobenzaprine), SSRI (i.e., citalopram), 1 SNRI (i.e., venlafaxine), gabapentin, OR tramadol
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella Titration Pack

Products Affected

- SAVELLA TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of 3 of the following drugs/ drug classes: 1 tricyclic antidepressant (i.e., amitriptyline), 1 muscle relaxant (i.e., cyclobenzaprine), SSRI (i.e., citalopram), 1 SNRI (i.e., venlafaxine), gabapentin, OR tramadol
QL Criteria	55 EA Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Seasonique

Products Affected

- SEASONIQUE

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

Semprex-D

Products Affected

- SEMPREX-D

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions AND A documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than /= 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription(OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product)- For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Serevent Diskus

Products Affected

- SEREVENT DISKUS

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

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 300 MG, 400 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 50 MG, 100 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	3 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 200 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	4 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel

Products Affected

- SEROQUEL ORAL TABLET 25 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	6 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 300 MG, 400 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 50 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	6 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 200 MG, 150 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral concentrate*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

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

Signifor

Products Affected

- SIGNIFOR

QL Criteria	10 Ampules Per 30 days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Signifor LAR

Products Affected

- SIGNIFOR LAR

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

Sildenafil Citrate

Products Affected

- *sildenafil citrate oral*

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

Silenor

Products Affected

- SILENOR

ST Criteria	A documented trial of 7 days (one week) each of generic doxepin AND zolpidem OR zolpidem er
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simcor

Products Affected

- SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 500-40 MG, 1000-40 MG

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

Simcor

Products Affected

- SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 750-20 MG, 500-20 MG, 1000-20 MG

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

Simponi

Products Affected

- SIMPONI

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

Simvastatin

Products Affected

- *simvastatin oral*

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

Singulair

Products Affected

- SINGULAIR

ST Criteria	Trial of one month of generic montelukast
QL Criteria	1 pack Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Singulair

Products Affected

- SINGULAIR

ST Criteria	Trial of one month of generic montelukast
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sirturo

Products Affected

- SIRTURO

QL Criteria	68 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sivextro

Products Affected

- SIVEXTRO ORAL

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

Skelid

Products Affected

- SKELID

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

Skyla

Products Affected

- SKYLA

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

Solia

Products Affected

- SOLIA

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

Solodyn

Products Affected

- SOLODYN

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sonata

Products Affected

- SONATA ORAL CAPSULE 5 MG

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	4 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sonata

Products Affected

- SONATA ORAL CAPSULE 10 MG

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Soolantra

Products Affected

- SOOLANTRA

ST Criteria	Trial of one month each of any of topical generic alternatives, metronidazole OR sulfacetamide sodium with sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sorilux

Products Affected

- SORILUX

ST Criteria	Trial of one month of calcipotriene or Tazorac
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Spiriva HandiHaler

Products Affected

- SPIRIVA HANDIHALER

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

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 1.25 MCG/ACT

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

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 2.5 MCG/ACT

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

Sprintec 28

Products Affected

- SPRINTEC 28

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

Sprix

Products Affected

- SPRIX

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

Sprycel

Products Affected

- SPRYCEL

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

Sronyx

Products Affected

- SRONYX

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

Stimate

Products Affected

- STIMATE

PA Criteria	Criteria Details
Covered Uses	Diagnosis of hemophilia A OR mild to moderate von Willebrand's disease (vWd)
Exclusion Criteria	
Required Medical Information	Documentation of greater than 5% Factor VIII coagulant activity.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stiolto Respimat

Products Affected

- STIOLTO RESPIMAT

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

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 25 MG, 40 MG, 60 MG, 10 MG, 18 MG

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

Strattera

Products Affected

- STRATTERA ORAL CAPSULE 80 MG, 100 MG

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

Striant

Products Affected

- STRIANT

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	2 buccals Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Striverdi Respimat

Products Affected

- STRIVERDI RESPIMAT

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of Foradil AND Serevent
QL Criteria	1 inhaler Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 8-2 MG, 4-1 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	90 pack Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL TABLET SUBLINGUAL

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	90 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	2 pack Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Subsys

Products Affected

- SUBSYS SUBLINGUAL LIQUID† 1200 (600 X 2) MCG, 1600 (800 X 2) MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

ST Criteria	Trial of one week of generic alternative: fentanyl transmucosal lozenge
QL Criteria	8 pack Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Subsys

Products Affected

- SUBSYS SUBLINGUAL LIQUID† 400 MCG, 600 MCG, 200 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

ST Criteria	Trial of one week of generic alternative: fentanyl transmucosal lozenge
QL Criteria	15 pack Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Subsys

Products Affected

- SUBSYS SUBLINGUAL LIQUID† 100 MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer painGeneral anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy** ORMember's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist ORMember is enrolled in a hospice program or meets hospice criteria ORMember's resident state or contract state is California and the member is terminally ill ORPatient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)ANDDocumentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process

ST Criteria	Trial of one week of generic alternative: fentanyl transmucosal lozenge
QL Criteria	15 ml Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sulfacetamide Sodium

Products Affected

- *sulfacetamide sodium ophthalmic solution*

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

SulfaSALAzine

Products Affected

- *sulfasalazine oral*

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

Sulfazine

Products Affected

- SULFAZINE

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

Sulfazine EC

Products Affected

- SULFAZINE EC

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

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate oral*

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

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous* 4 mg/0.5ml, 6 mg/0.5ml*

QL Criteria	10 cartridges Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sumavel DosePro

Products Affected

- SUMAVEL DOSEPRO

ST Criteria	Trial of 1 month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
QL Criteria	6 syringes Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected

- SUTENT ORAL CAPSULE 25 MG, 50 MG, 12.5 MG

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

Syeda

Products Affected

- SYEDA

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

Symbicort

Products Affected

- SYMBICORT

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

Symbicort

Products Affected

- SYMBICORT

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

Symbyax

Products Affected

- SYMBYAX

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

SymlinPen 120

Products Affected

- SYMLINPEN 120

PA Criteria	Criteria Details
Covered Uses	Diabetes
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type I or type II diabetes AND Concurrent use of a rapid or short-acting insulin i.e., Humalog or regular insulin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SymlinPen 60

Products Affected

- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	Diabetes
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type I or type II diabetes AND Concurrent use of a rapid or short-acting insulin i.e., Humalog or regular insulin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synjardy

Products Affected

- SYNJARDY

ST Criteria	Trial of 1 month of Invokana (single entity or combination)
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tacrolimus

Products Affected

- *tacrolimus external*

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

Tafinlar

Products Affected

- TAFINLAR

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

Tamiflu

Products Affected

- TAMIFLU ORAL CAPSULE 30 MG, 45 MG

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

Tamiflu

Products Affected

- TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML

QL Criteria	480 pen Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tamiflu

Products Affected

- TAMIFLU ORAL CAPSULE 75 MG

QL Criteria	2 pack Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tamsulosin HCl

Products Affected

- *tamsulosin hcl*

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member has documented diagnosis of Urethral syndrome (urinary hesitancy, frequency, and dysuria) OR Member has documented diagnosis of intractable micturition difficulties (difficulty passing urine) OR Member has documented diagnosis of Ureteral calculi/Kidney stones OR Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tanzeum

Products Affected

- TANZEUM

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 2
Exclusion Criteria	Tanzeum is not covered for members with: 1) Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis2) Diagnosis of Type 1 Diabetes3) Treatment of diabetic ketoacidosis4) Pediatric patients5) Patients with severe gastrointestinal diseases, including gastroparesis.6) Patients with multiple endocrine neoplasia syndrome type 2 (MEN2)7) History of family history of medullary thyroid carcinoma (MTC)8) Patients with a history of pancreatitis9) Concurrent use with alpha-glucosidase inhibitors (Precose, Glyset) or DPP-4 inhibitors (Single entity or in combination)
Required Medical Information	A1C level is greater than 6.5%
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	4 pens Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tarceva

Products Affected

- TARCEVA

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

Tasigna

Products Affected

- TASIGNA

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

Tazorac

Products Affected

- TAZORAC

PA Criteria	Criteria Details
Covered Uses	acne vulgaris plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris, OR A documented diagnosis of plaque psoriasis
Age Restrictions	greater than 35 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Technivie

Products Affected

- TECHNIVIE

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

Tekamlo

Products Affected

- TEKAMLO

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

Tekturna

Products Affected

- TEKTURNA

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

Tekturna HCT

Products Affected

- TEKTURNA HCT ORAL TABLET 150-25 MG, 150-12.5 MG

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

Temodar

Products Affected

- TEMODAR ORAL

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

Temozolomide

Products Affected

- *temozolomide*

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

Terbinafine HCl

Products Affected

- *terbinafine hcl oral*

PA Criteria	Criteria Details
Covered Uses	Cutaneous leishmaniasis Cutaneous sporotrichosis Paracoccidioidomycosis Seborrheic dermatitis Tinea capitis Onychomycosis (Tinea unguium)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the below indications and specified criteria AND A documented contraindication or intolerance or allergy or failure of an adequate trial of preferred generic terbinafine (if request is for brand Lamisil) Chromoblastomycosis Cutaneous dermatophyte infection: NOTE: tinea pedis/manuum(athletes foot/hand), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor] AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one topical antifungal Cutaneous leishmaniasis Cutaneous sporotrichosis Paracoccidioidomycosis Seborrheic dermatitis Tinea capitis Onychomycosis (Tinea unguium) due to dermatophyte AND A documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

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

Testim

Products Affected

- TESTIM

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	10 GM Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal 10 mg/act (2%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	4 pumps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal 25 mg/2.5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	1 packet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal 50 mg/5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	60 packets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal 12.5 mg/act (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	4 pumps Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 25 mg*

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

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg*

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

Tetracycline HCl

Products Affected

- *tetracycline hcl oral*

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Teveten

Products Affected

- TEVETEN ORAL TABLET 600 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Teveten HCT

Products Affected

- TEVETEN HCT

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 4 mg*

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 2 mg*

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

Tilia Fe

Products Affected

- TILIA FE

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

Tivorbex

Products Affected

- TIVORBEX

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

TobraDex

Products Affected

- TOBRADEX OPHTHALMIC SUSPENSION

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

TobraDex ST

Products Affected

- TOBRADEX ST

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

Tobramycin

Products Affected

- *tobramycin ophthalmic*

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

Tobramycin-Dexamethasone

Products Affected

- *tobramycin-dexamethasone*

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

Tobrex

Products Affected

- TOBREX OPHTHALMIC SOLUTION

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

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

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

Topamax Sprinkle

Products Affected

- TOPAMAX SPRINKLE

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

Topiramate

Products Affected

- *topiramate oral capsule sprinkle*

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

Toujeo SoloStar

Products Affected

- TOUJEO SOLOSTAR

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of 1 month of Levemir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tradjenta

Products Affected

- TRADJENTA

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 2
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Januvia OR Onglyza (single entity or combination)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral capsule extended release 24 hour 200 mg, 300 mg, 100 mg*

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

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral tablet extended release 24 hr**

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

TraMADol HCl ER (Biphasic)

Products Affected

- *tramadol hcl er (biphasic)*

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

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

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

Travatan Z

Products Affected

- TRAVATAN Z

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

Travoprost

Products Affected

- *travoprost*

PA Criteria	Criteria Details
Covered Uses	glaucoma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 week of latanoprost AND 1 week of Travatan Z
QL Criteria	3 ML Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin

Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin

Products Affected

- *tretinoin oral*

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	30 days maximum Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin Microsphere

Products Affected

- *tretinoin microsphere*

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin Microsphere Pump

Products Affected

- *tretinoin microsphere pump*

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretin-X

Products Affected

- TRETIN-X EXTERNAL CREAM

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of Tretinoin and one of the following: adapalene, benzoyl peroxide, topical clindamycin, topical erythromycin, sulfacetamide w/sulfur
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Treximet

Products Affected

- TREXIMET

ST Criteria	Trial of 1 month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan in combination with 500mg naproxen
QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trezix

Products Affected

- TREZIX ORAL CAPSULE 320.5-30-16 MG

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

Tribenzor

Products Affected

- TRIBENZOR

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension, AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any two preferred alternatives from the following: candesartan/hctz, in combination with amlodipine, eprosartan/hctz, in combination with amlodipine, irbesartan/hctz, in combination with amlodipine, losartan/hctz, in combination with amlodipine, telmisartan/hctz in combination with amlodipine, valsartan/hctz in combination with amlodipine, telmisartan/ amlodipine in combination with hctz OR Exforge HCT
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any two alternatives from the following: candesartan/hctz in combination with amlodipine, eprosartan/hctz in combination with amlodipine, irbesartan/hctz in combination with amlodipine, losartan/hctz in combination with amlodipine, telmisartan/hctz in combination with amlodipine, valsartan/hctz in combination with amlodipine, telmisartan/ amlodipine in combination with hctz OR Exforge HCT
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tricor

Products Affected

- TRICOR

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Estarylla

Products Affected

- TRI-ESTARYLLA

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

Trifluridine

Products Affected

- *trifluridine ophthalmic*

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

Triglide

Products Affected

- TRIGLIDE ORAL TABLET 160 MG

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Legest Fe

Products Affected

- TRI-LEGEST FE

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

Tri-Linyah

Products Affected

- TRI-LINYAH

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

Trilipix

Products Affected

- TRILIPIX

ST Criteria	Trial of one month of any preferred fenofibrate product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TriNessa (28)

Products Affected

- TRINESSA (28)

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

Tri-Previfem

Products Affected

- TRI-PREVIFEM

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

Tri-Sprintec

Products Affected

- TRI-SPRINTEC

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

Trivora (28)

Products Affected

- TRIVORA (28)

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

Trokendi XR

Products Affected

- TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 25 MG, 100 MG, 50 MG

ST Criteria	A documented trial of one month of the preferred generic alternative, topiramate
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trokendi XR

Products Affected

- TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG

ST Criteria	A documented trial of one month of the preferred generic alternative, topiramate
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trospium Chloride

Products Affected

- *trospium chloride*

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

Trospium Chloride ER

Products Affected

- *trospium chloride er*

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

Trulicity

Products Affected

- TRULICITY

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

Tudorza Pressair

Products Affected

- TUDORZA PRESSAIR

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month of Spiriva
QL Criteria	1 pack Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Twinject

Products Affected

- TWINJECT

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

Tybost

Products Affected

- TYBOST

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

Tykerb

Products Affected

- TYKERB

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

Uceris

Products Affected

- UCERIS ORAL

ST Criteria	Trial of Ascol HD, Delzicol, Lialda OR Pentasa
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uceris

Products Affected

- UCERIS

ST Criteria	Trial of Ascol HD, Delzicol, Lialda OR Pentasa
QL Criteria	4 canisters Per 42 months
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uloric

Products Affected

- ULORIC

ST Criteria	Trial of one month of generic allopurinol
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultram ER

Products Affected

- ULTRAM ER

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

Ultresa

Products Affected

- ULTRESA

ST Criteria	Trial of two weeks of two alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uroxatral

Products Affected

- UROXATRAL

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
ST Criteria	Trial of one month of the drug?s generic equivalent alfuzosin
Notes/ References	
Revision Date	Prior Authorization: August 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valcyte

Products Affected

- VALCYTE ORAL SOLUTION RECONSTITUTED

QL Criteria	1000 ml Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valcyte

Products Affected

- VALCYTE ORAL TABLET

QL Criteria	102 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl*

QL Criteria	102 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valsartan-Hydrochlorothiazide

Products Affected

- *valsartan-hydrochlorothiazide oral tablet*
  160-25 mg, 160-12.5 mg, 80-12.5 mg

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

Valtrex

Products Affected

- VALTREX

ST Criteria	Trial of one week of generic valacyclovir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vascepa

Products Affected

- VASCEPA

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

Vecamyl

Products Affected

- VECAMYL

PA Criteria	Criteria Details
Covered Uses	severe essential hypertension uncomplicated malignant hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of moderately severe to severe essential hypertension or uncomplicated malignant hypertension AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of a triple-drug combination from the preferred alternatives from the following classes: Diuretics Angiotensin-Converting Enzyme Inhibitors Angiotensin II Receptor Antagonists Beta-Adrenergic Blockers Calcium Channel Blockers Note: Selection of three medications must each be from a different class.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month of a triple-drug combination from the preferred alternatives from the following classes: Diuretics Angiotensin-Converting Enzyme Inhibitors Angiotensin II Receptor Antagonists Beta-Adrenergic Blockers Calcium Channel Blockers Note: Selection of three medications must each be from a different class.
QL Criteria	10 tab Per 1 Day
Notes/ References	

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

Velivet

Products Affected

- VELIVET

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 75 mg, 37.5 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hr**

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral tablet extended release 24 hr**

ST Criteria	Trial of venlafaxine (NSO)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ventolin HFA

Products Affected

- VENTOLIN HFA

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

Veramyst

Products Affected

- VERAMYST

ST Criteria	Trial of 2 weeks each of 2 of Nasonex, budesonide, flunisolide, fluticasone, OR triamcinolone.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verdeso

Products Affected

- VERDESO

ST Criteria	Trial of two weeks of one generic desonide alternative any dosage form
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Versacloz

Products Affected

- VERSACLOZ

ST Criteria	Trial of 1 month of clozapine
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

VESIcare

Products Affected

- VESICARE

ST Criteria	Trial of 1 month of trospium/er OR tolteridine/er
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vestura

Products Affected

- VESTURA

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

Vibramycin

Products Affected

- VIBRAMYCIN

PA Criteria	Criteria Details
Covered Uses	Documented to be 8 years of age or older (Note: see required medical information section if less than 8 years of age
Exclusion Criteria	
Required Medical Information	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)
Age Restrictions	Covered for members 8 years and older. If less than 8 years old please see coverage criteria requirements.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Victoza

Products Affected

- VICTOZA

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

Victrelis

Products Affected

- VICTRELIS

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

Vigamox

Products Affected

- VIGAMOX

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

Viibryd

Products Affected

- VIIBRYD

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd

Products Affected

- VIIBRYD

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
QL Criteria	1 kit Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd Starter Pack

Products Affected

- VIIBRYD STARTER PACK

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose)
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimovo

Products Affected

- VIMOVO

ST Criteria	Trial of two weeks of one preferred generic nonsteroidal anti-inflammatory agent
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected

- VIMPAT ORAL TABLET 150 MG, 200 MG, 100 MG

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

Vimpat

Products Affected

- VIMPAT ORAL SOLUTION

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

Vimpat

Products Affected

- VIMPAT ORAL TABLET 50 MG

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

Viokace

Products Affected

- VIOKACE

ST Criteria	Trial of two weeks of two alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viorele

Products Affected

- *viorele*

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

Viramune

Products Affected

- VIRAMUNE

ST Criteria	Trial of one month of the medication's preferred generic equivalent alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viramune XR

Products Affected

- VIRAMUNE XR

ST Criteria	Trial of one month of the medication's preferred generic equivalent alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viroptic

Products Affected

- VIROPTIC

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

Vivelle-Dot

Products Affected

- VIVELLE-DOT TRANSDERMAL PATCH BIWEEKLY 0.075 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.1 MG/24HR

QL Criteria	8 patch Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vivelle-Dot

Products Affected

- VIVELLE-DOT TRANSDERMAL PATCH BIWEEKLY 0.025 MG/24HR

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

Vogelxo

Products Affected

- VOGELXO

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	60 packets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vogelxo Pump

Products Affected

- VOGELXO PUMP

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	1. female members2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate3. patient 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month each of AndroGel AND Testim
QL Criteria	4 pumps Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Voltaren

Products Affected

- VOLTAREN TRANSDERMAL

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

Votrient

Products Affected

- VOTRIENT

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

Vyfemla

Products Affected

- VYFEMLA

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

Vytorin

Products Affected

- VYTORIN

ST Criteria	1 month trial of ONE generic fluvastatin, lovastatin, pravastatin, simvastatin, OR atorvastatin AND Crestor
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyvanse

Products Affected

- VYVANSE

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

Vyvanse

Products Affected

- VYVANSE

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

Wellbutrin

Products Affected

- WELLBUTRIN

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

Wellbutrin SR

Products Affected

- WELLBUTRIN SR

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

Wellbutrin XL

Products Affected

- WELLBUTRIN XL

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

Wera

Products Affected

- WERA

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

Wide-Seal Diaphragm 60

Products Affected

- WIDE-SEAL DIAPHRAGM 60

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

Wide-Seal Diaphragm 65

Products Affected

- WIDE-SEAL DIAPHRAGM 65

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

Wide-Seal Diaphragm 70

Products Affected

- WIDE-SEAL DIAPHRAGM 70

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

Wide-Seal Diaphragm 75

Products Affected

- WIDE-SEAL DIAPHRAGM 75

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

Wide-Seal Diaphragm 80

Products Affected

- WIDE-SEAL DIAPHRAGM 80

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

Wide-Seal Diaphragm 85

Products Affected

- WIDE-SEAL DIAPHRAGM 85

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

Wide-Seal Diaphragm 90

Products Affected

- WIDE-SEAL DIAPHRAGM 90

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

Wide-Seal Diaphragm 95

Products Affected

- WIDE-SEAL DIAPHRAGM 95

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

Wymzya Fe

Products Affected

- WYMZYA FE

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

Xalatan

Products Affected

- XALATAN

PA Criteria	Criteria Details
Covered Uses	glaucoma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 week of latanoprost AND 1 week of Travatan Z
QL Criteria	3 ML Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xalkori

Products Affected

- XALKORI

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

Xanax XR

Products Affected

- XANAX XR

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

Xarelto

Products Affected

- XARELTO ORAL TABLET 10 MG

QL Criteria	35 tab Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto

Products Affected

- XARELTO ORAL TABLET 15 MG

QL Criteria	42 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto

Products Affected

- XARELTO ORAL TABLET 20 MG

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

Xarelto Starter Pack

Products Affected

- XARELTO STARTER PACK

QL Criteria	2 packs Per 325 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeljanz

Products Affected

- XELJANZ

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

Xeloda

Products Affected

- XELODA

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

Xenazine

Products Affected

- XENAZINE ORAL TABLET 12.5 MG

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

Xenazine

Products Affected

- XENAZINE ORAL TABLET 25 MG

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

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 200 MG

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR A documented diagnosis of hepatic encephalopathy
Exclusion Criteria	Small intestinal bacterial overgrowth (SIBO)
Required Medical Information	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR A documented diagnosis of hepatic encephalopathy AND A documented: Contraindication to one preferred alternative agent indicated for the member's condition OR Intolerance to one preferred alternative agent indicated for the member's condition OR Allergy to one preferred alternative agent indicated for the member's condition OR Failure of an adequate trial of two weeks of one preferred alternative agent indicated for the member's condition
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Hepatic encephalopathy: One year Traveler's Diarrhea: 1 Week
Other Criteria	
QL Criteria	9 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR A documented diagnosis of hepatic encephalopathy
Exclusion Criteria	Small intestinal bacterial overgrowth (SIBO)
Required Medical Information	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR A documented diagnosis of hepatic encephalopathy AND A documented: Contraindication to one preferred alternative agent indicated for the member's condition OR Intolerance to one preferred alternative agent indicated for the member's condition OR Allergy to one preferred alternative agent indicated for the member's condition OR Failure of an adequate trial of two weeks of one preferred alternative agent indicated for the member's condition
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Hepatic encephalopathy: One year Traveler's Diarrhea: 1 Week
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xigduo XR

Products Affected

- XIGDUO XR

ST Criteria	Trial of one month of Invokana (single entity or combination)
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xopenex HFA

Products Affected

- XOPENEX HFA

PA Criteria	Criteria Details
Covered Uses	Treatment and prevention of bronchospasms
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 week each of Ventolin HFA AND Proair
QL Criteria	2 inhalers Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xtandi

Products Affected

- XTANDI

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

Xulane

Products Affected

- XULANE

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

Xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	Cataplexy and narcolepsy Narcolepsy, to treat excessive daytime sleepiness
Exclusion Criteria	
Required Medical Information	(A or B or C) and D A. Member has a documented diagnosis of narcolepsy confirmed by sleep lab evaluation OR B. Member has episodes of cataplexy including hypnagogic hallucinations and/or sleep paralysis OR C. Member has excessive daytime sleepiness with symptoms that limit the ability to perform normal daily activities AND D. Member and physician are enrolled in the Xyrem Success Program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	18 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyzal

Products Affected

- XYZAL ORAL SOLUTION

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

Xyzal

Products Affected

- XYZAL ORAL TABLET

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

Zaleplon

Products Affected

- *zaleplon oral capsule 10 mg*

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

Zaleplon

Products Affected

- *zaleplon oral capsule 5 mg*

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

Zarah

Products Affected

- ZARAH

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

Zecuity

Products Affected

- ZECUITY

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

Zegerid

Products Affected

- ZEGERID ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 pack Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid

Products Affected

- ZEGERID ORAL CAPSULE 40-1100 MG

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux diseaseDuodenal ulcer diseaseGastric hypersecretion
Exclusion Criteria	Aetna does NOT consider prescription PPIs to be medically necessary for members with the following indications:1. Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: a. The heartburn can be controlled by use of OTC medications AND b. There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis AND c. There are no symptoms of a more complicated GI condition.*OR 2. Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications OR 3. Any of the following diagnoses when NOT in combination with a diagnosis listed under A above:DyspepsiaGastritis or duodenitisGastroparesisGastric bypass surgery(surgical prophylaxis only)Hiatal herniaSchatzki's ring (esophagogastric ring)
Required Medical Information	A. Documented diagnosis listed below (no requirement for nonprescription Prilosec OTC)IndicationUlcersGastrojejunal ulcer - active: maintenanceHealing of NSAID-associated gastric ulcerMaintenance of healed duodenal ulcersStress ulcer/surgical prophylaxisTreatment of benign gastric ulcerTreatment of duodenal ulcersOther GI ConditionsGastric residual reductionGastrointestinal bleedGERD - moderate to severe with symptomsGERD- with atypical symptoms or complications (ex dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture)Healing erosive esophagitisHelicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (Additional documentation of two concurrent antibiotics that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required.Examples of antibiotics include: amoxicillin or clarithromycin or metronidazole or tetracycline)Maintaining healing of erosive esophagitisPathologic hypersecretory conditions (Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1:)Preventative NeedsMember is on chronic oral corticosteroid therapy (greater than or equal to 60 days)Member is Post transplant and/or MD is a transplant specialistMember is receiving chemotherapy or radiation therapy for a current cancer diagnosisReducing risk of NSAID-associated gastric ulcerORB. Documented diagnosis of other GI condition for which Prilosec OTC and Prevacid 24 hour (OTC) are indicated (heartburn, chronic reflux), the use of a PPI is required, AND one of the below:Intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) ORFailure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg(OTC)

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: Member has a diagnosis of a pathological hypersecretory condition [e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)] OR Member is being treated for Barrett's esophagus OR Member is being treated for eradication of H. pylori (triple therapy only: 30-day duration) OR Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: a. Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal)b. Member is experiencing acid breakthrough OR Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium OR Member is an infant, 1 month to 1 year of age, and has a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Nexium granules
QL Criteria	1 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zelapar

Products Affected

- ZELAPAR

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

Zelboraf

Products Affected

- ZELBORAF

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

Zenatane

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	severe recalcitrant nodular or cystic acne
Exclusion Criteria	
Required Medical Information	Member already has evidence of scarring ANDMember is enrolled in the FDA iPLEDGE program (females of childbearing potential ONLY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria:1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has received a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
ST Criteria	Trial of 1 generic oral antibiotic prescribed for the treatment of acne (i.e., minocycline or doxycycline)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 17, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenchent

Products Affected

- ZENCHENT

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

Zenchent FE

Products Affected

- ZENCHENT FE

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

Zenzedi

Products Affected

- ZENZEDI

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy
ST Criteria	Trial of 14 days each of 3 of: amphet/dextroamphetamine/ sr, dexmethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zeosa

Products Affected

- ZEOSA

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

Zerit

Products Affected

- ZERIT

ST Criteria	Trial of one month of the medication's preferred generic equivalent alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zetia

Products Affected

- ZETIA

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

Zetonna

Products Affected

- ZETONNA

ST Criteria	Trial of 2 weeks each of 2 of Nasonex, budesonide, flunisolide, fluticasone, OR triamcinolone.
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziagen

Products Affected

- ZIAGEN

ST Criteria	Trial of one month of the medication's preferred generic equivalent alternative
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zioptan

Products Affected

- ZIOPTAN

PA Criteria	Criteria Details
Covered Uses	glaucoma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 week of latanoprost AND 1 week of Travatan Z
QL Criteria	1 unit Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziprasidone HCl

Products Affected

- *ziprasidone hcl*

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

Zocor

Products Affected

- ZOCOR

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

Zofran

Products Affected

- ZOFRAN ORAL SOLUTION

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

Zofran

Products Affected

- ZOFRAN ORAL TABLET

QL Criteria	12 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zofran ODT

Products Affected

- ZOFRAN ODT

QL Criteria	12 tab Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zohydro ER

Products Affected

- ZOHYDRO ER

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	A. Documentation of progression through the World Health Organization analgesic ladder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR Member is enrolled in a hospice program or meets hospice criteria OR Member's resident state or contract state is California and the member is terminally ill OR Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference) Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) AND Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain AND formal pain evaluation has been documented AND Other pain management regimens have been inadequate

ST Criteria	Trial of 1 month each of controlled-release morphine sulfate tablets (MS Contin) and oxymorphone extended release (Opana ER)
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoledronic Acid

Products Affected

- *zoledronic acid intravenous* concentrate*

QL Criteria	1 vial Per 21 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoledronic Acid

Products Affected

- *zoledronic acid intravenous* solution 5 mg/100ml*

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

Zolinza

Products Affected

- ZOLINZA

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

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 5 mg*
- *zolmitriptan oral tablet dispersible 5 mg*

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

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 2.5 mg*
- *zolmitriptan oral tablet dispersible 2.5 mg*

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

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 100 MG

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

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 25 MG

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

Zoloft

Products Affected

- ZOLOFT ORAL CONCENTRATE

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

Zoloft

Products Affected

- ZOLOFT ORAL TABLET 50 MG

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

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate oral tablet 5 mg*

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

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate oral tablet 10 mg*

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

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

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

Zolpimist

Products Affected

- ZOLPIMIST

ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem or zolpidem er.
QL Criteria	1 bottle Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zometa

Products Affected

- ZOMETA INTRAVENOUS* SOLUTION

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

Zometa

Products Affected

- ZOMETA INTRAVENOUS* CONCENTRATE

QL Criteria	1 vial Per 21 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- ZOMIG

ST Criteria	Trial of 1 month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
QL Criteria	6 bottles Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- ZOMIG

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

Zomig

Products Affected

- ZOMIG

ST Criteria	Trial of 1 month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
QL Criteria	6 ml Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig ZMT

Products Affected

- ZOMIG ZMT

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

Zorvolex

Products Affected

- ZORVOLEX

PA Criteria	Criteria Details
Covered Uses	mild to moderate acute pain in adults
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild to moderate acute pain in adults, AND A documented contraindication or allergy or intolerance or failure of an adequate trial of two weeks of the preferred generic alternative, diclofenac
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of two weeks of generic diclofenac
QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovia 1/35E (28)

Products Affected

- ZOVIA 1/35E (28)

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

Zovia 1/50E (28)

Products Affected

- ZOVIA 1/50E (28)

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

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
ST Criteria	Trial of 1 month of buprenorphine-naloxone sublingual tablet or Suboxone Film
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zubsolv

Products Affected

- ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG

PA Criteria	Criteria Details
Covered Uses	Opioid dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program and/or counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and the prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	LOADED IN MMIT AS: For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
ST Criteria	Trial of 1 month of buprenorphine-naloxone sublingual tablet or Suboxone Film
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zuplenz

Products Affected

- ZUPLENZ

QL Criteria	12 pack Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyclara

Products Affected

- ZYCLARA

PA Criteria	Criteria Details
Covered Uses	actinic keratosis external genital warts perianal warts (Condyloma acuminate)
Exclusion Criteria	
Required Medical Information	trial of one month of the preferred generic alternative, imiquimod
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	56 EA Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyclara Pump

Products Affected

- ZYCLARA PUMP EXTERNAL CREAM 3.75 %

PA Criteria	Criteria Details
Covered Uses	actinic keratosis external genital warts perianal warts (Condyloma acuminate)
Exclusion Criteria	
Required Medical Information	trial of one month of the preferred generic alternative, imiquimod
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	56 packets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyclara Pump

Products Affected

- ZYCLARA PUMP EXTERNAL CREAM 2.5 %

PA Criteria	Criteria Details
Covered Uses	actinic keratosis external genital warts perianal warts (Condyloma acuminate)
Exclusion Criteria	
Required Medical Information	trial of one month of the preferred generic alternative, imiquimod
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 bottle Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zylet

Products Affected

- ZYLET

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

Zymaxid

Products Affected

- ZYMAXID

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

ZyPREXA

Products Affected

- ZYPREXA ORAL TABLET 10 MG, 20 MG, 5 MG, 15 MG, 7.5 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZyPREXA

Products Affected

- ZYPREXA ORAL TABLET 2.5 MG

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	2 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZyPREXA Zydis

Products Affected

- ZYPREXA ZYDIS

ST Criteria	Trial of 1 month each of: 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zytiga

Products Affected

- ZYTIGA

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

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