

2015 Aetna Pharmacy Plan Drug List - Self Insured

# Abilify

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**Products Affected**

- ABILIFY ORAL TABLET

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

# Abilify

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## Products Affected

- ABILIFY ORAL SOLUTION

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

# Abilify Discmelt

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## Products Affected

- ABILIFY DISCMELT

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

# Abilify Maintena

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## Products Affected

- ABILIFY MAINTENA

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

# Absorica

## Products Affected

- ABSORICA ORAL CAPSULE 25 MG, 35 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	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 recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Absorica

## Products Affected

- ABSORICA ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	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 recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Abstral

## Products Affected

- ABSTRAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Breakthrough cancer pain, General anesthesia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation 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</p>

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

<b>ST Criteria</b>	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)
<b>QL Criteria</b>	15 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Acanya

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## Products Affected

- ACANYA

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

# Accu-Chek Active

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## Products Affected

- ACCU-CHEK ACTIVE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Aviva

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## Products Affected

- ACCU-CHEK AVIVA IN VITRO STRIP

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Aviva Plus

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## Products Affected

- ACCU-CHEK AVIVA PLUS IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Comfort Curve

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## Products Affected

- ACCU-CHEK COMFORT CURVE IN VITRO STRIP

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Compact

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## Products Affected

- ACCU-CHEK COMPACT

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Compact Plus

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## Products Affected

- ACCU-CHEK COMPACT PLUS

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accu-Chek Compact Test Drum

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## Products Affected

- ACCU-CHEK COMPACT TEST DRUM

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Accu-Chek SmartView

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## Products Affected

- ACCU-CHEK SMARTVIEW

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Accutrend Glucose

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## Products Affected

- ACCUTREND GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aciphex

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## Products Affected

- ACIPHEX

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

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

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AcipHex Sprinkle

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## Products Affected

- ACIPHEX SPRINKLE

PA Criteria	Criteria Details
<b>Covered Uses</b>	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
<b>Exclusion Criteria</b>	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Actiq

## Products Affected

- ACTIQ

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer pain, General anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.</p> <p>*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</p>

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

<b>ST Criteria</b>	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)
<b>QL Criteria</b>	15 lollipops Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Activella

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## Products Affected

- ACTIVELLA

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

# Actonel

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## Products Affected

- ACTONEL ORAL TABLET 5 MG, 30 MG

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

# Actonel

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## Products Affected

- ACTONEL ORAL TABLET 150 MG

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

# Actonel

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## Products Affected

- ACTONEL ORAL TABLET 35 MG

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

# Actoplus Met

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## Products Affected

- ACTOPLUS MET

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

# Actoplus met XR

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## Products Affected

- ACTOPLUS MET XR

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



# Actos

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## Products Affected

- ACTOS

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

# Acular

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## Products Affected

- ACULAR

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

# Acular LS

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## Products Affected

- ACULAR LS

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

# Acura Blood Glucose Test

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## Products Affected

- ACURA BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Acuvail

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## Products Affected

- ACUVAIL

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

# Adcirca

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## Products Affected

- ADCIRCA

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

# Adderall

## Products Affected

- ADDERALL ORAL TABLET 30 MG, 5 MG, 7.5 MG, 10 MG, 15 MG, 12.5 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamylphenidate/ 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

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## Products Affected

- ADEMPAS

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

# Adoxa

## Products Affected

- ADOXA

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Adoxa Pak 1/100

## Products Affected

- ADOXA PAK 1/100

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Adoxa Pak 1/150

## Products Affected

- ADOXA PAK 1/150

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Adoxa Pak 2/100

## Products Affected

- ADOXA PAK 2/100

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# 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 one: Auvi-Q, Epipen, OR Epipen JR
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advair Diskus

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## Products Affected

- ADVAIR DISKUS

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

# Advair HFA

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## Products Affected

- ADVAIR HFA

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

# Advance Intuition Test

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## Products Affected

- ADVANCE INTUITION TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advance Micro-Draw Test

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## Products Affected

- ADVANCE MICRO-DRAW TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advicor

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## Products Affected

- ADVICOR

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



# Advocate Redi-Code

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## Products Affected

- ADVOCATE REDI-CODE IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advocate Redi-Code+ Test

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## Products Affected

- ADVOCATE REDI-CODE+ TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Advocate Test

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## Products Affected

- ADVOCATE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Afinitor

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## Products Affected

- AFINITOR

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

# Afinitor Disperz

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## Products Affected

- AFINITOR DISPERZ

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Diagnosis of type 1 or type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following:1) In patients with type 1 diabetes, concomitant use of long-acting insulin (e.g., Levamir or Lantus).2) In all Patients: No history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD).3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month of one alternative 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

# AgaMatrix AMP Test

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## Products Affected

- AGAMATRIX AMP TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AgaMatrix Jazz Test

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## Products Affected

- AGAMATRIX JAZZ TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# AgaMatrix KeyNote Test

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## Products Affected

- AGAMATRIX KEYNOTE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AgaMatrix Presto Test

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## Products Affected

- AGAMATRIX PRESTO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Akynzeo

## Products Affected

- AKYNZEO

PA Criteria	Criteria Details
Covered Uses	Nausea and vomiting associated with cancer chemotherapy
Exclusion Criteria	
Required Medical Information	a documented diagnosis of Nausea and vomiting associated with cancer chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
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

# Albertsons Test

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## Products Affected

- *albertsons test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aldara

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## Products Affected

- ALDARA

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

# Alendronate Sodium

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## Products Affected

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

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

# Alendronate Sodium

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## Products Affected

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

<b>QL Criteria</b>	1 tab Per 7 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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	All FDA Covered Indications
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	
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Almotriptan Malate

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## Products Affected

- *almotriptan malate*

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

# Alora

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## Products Affected

- ALORA

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

# Alosetron HCl

## Products Affected

- *alose tron hcl*

PA Criteria	Criteria Details
Covered Uses	Irritable bowel syndrome
Exclusion Criteria	
Required Medical Information	(1)A female patient with a diagnosis of severe* irritable bowel syndrome (IBS) with primary symptom of diarrhea with chronic IBS symptoms (generally lasting 6 months or longer), and (2) anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded, and (3) failure of response to at least one conventional therapy agent for at least one month
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	*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.
Notes/References	
Revision Date	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ALPRAZolam ER

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## Products Affected

- *alprazolam er*

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

# ALPRAZolam XR

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## Products Affected

- *alprazolam xr*

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

# Alsuma

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## Products Affected

- ALSUMA

<b>QL Criteria</b>	10 vials Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Altavera

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## Products Affected

- ALTAVERA

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

# Altprev

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## Products Affected

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

<b>ST Criteria</b>	Trial of ONE generic statin: atorvastatin, fluvastatin, lovastatin, pravastatin, or simvastatin
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Altoprev

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## Products Affected

- ALTOPREV ORAL TABLET EXTENDED  
RELEASE 24 HR\* 40 MG

<b>ST Criteria</b>	Trial of ONE generic statin: atorvastatin, fluvastatin, lovastatin, pravastatin, or simvastatin
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Alyacen 1/35

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## Products Affected

- *alyacen 1/35*

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

# Alyacen 7/7/7

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## Products Affected

- *alyacen 7/7/7*

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

# Ambien

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## Products Affected

- AMBIEN ORAL TABLET 10 MG

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

# Ambien

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## Products Affected

- AMBIEN ORAL TABLET 5 MG

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

# Ambien CR

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## Products Affected

- AMBIEN CR

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

# Amerge

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## Products Affected

- AMERGE

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

# Amethia

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## Products Affected

- AMETHIA

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



# Amethia Lo

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## Products Affected

- AMETHIA LO

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

# Amitiza

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## Products Affected

- AMITIZA

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

# Amlodipine Besylate-Valsartan

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## Products Affected

- *amlodipine besylate-valsartan*

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

# Amlodipine-Valsartan-HCTZ

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## Products Affected

- *amlodipine-valsartan-hctz*

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

# Amnesteem

## Products Affected

- AMNESTEEM

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	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 recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Amphetamine-Dextroamphet ER

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## Products Affected

- *amphetamine-dextroamphet er*

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

# Amphetamine-Dextroamphetamine

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## Products Affected

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

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

# Amphetamine-Dextroamphetamine

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## Products Affected

- *amphetamine-dextroamphetamine oral tablet*  
20 mg

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



# Ampyra

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## Products Affected

- AMPYRA

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

# Amrix

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## Products Affected

- AMRIX

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

# Amturnide

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## Products Affected

- AMTURNIDE

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

# Androderm

## Products Affected

- ANDRODERM TRANSDERMAL PATCH 24  
HR 2 MG/24HR, 4 MG/24HR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	1 patch Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015</p>

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

# AndroGel

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 pack Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# AndroGel

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 packs Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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

# AndroGel

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	60 packs Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# AndroGel Pump

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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



# AndroGel Pump

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Angeliq

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## Products Affected

- ANGELIQ

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

# Angeliq

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## Products Affected

- ANGELIQ

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

# Anoro Ellipta

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## Products Affected

- ANORO ELLIPTA

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

# Antara

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## Products Affected

- ANTARA

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

# Antibiotic Ear

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## Products Affected

- *antibiotic ear*

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

# Anzemet

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## Products Affected

- ANZEMET ORAL

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

# APAP-Caff-Dihydrocodeine

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## Products Affected

- *apap-caff-dihydrocodeine oral capsule*

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



# Aplenzin

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## Products Affected

- APLENZIN

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

# Apri

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## Products Affected

- APRI

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

# Apriso

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## Products Affected

- APRISO

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

# Aptensio XR

## Products Affected

- APTENSIO 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr,Strattera, OR Vyvanse
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aralen

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## Products Affected

- ARALEN

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

# Aranelle

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## Products Affected

- ARANELLE

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

# Arcapta Neohaler

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## Products Affected

- ARCAPTA NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Ostructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aricept

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## Products Affected

- ARICEPT

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



# Aricept ODT

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## Products Affected

- ARICEPT ODT

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

# ARIPiprazole

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## Products Affected

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

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

# ARIPiprazole

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## Products Affected

- *aripiprazole oral solution*

<b>QL Criteria</b>	30 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial and failure of two of the following: Asmanex, Qvar, or Flovent
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

# Asacol HD

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## Products Affected

- ASACOL HD

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

# Assure 3 Test

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## Products Affected

- ASSURE 3 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Assure 4 Test

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## Products Affected

- ASSURE 4 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Assure II

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## Products Affected

- ASSURE II

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Assure II Check

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## Products Affected

- ASSURE II CHECK

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Assure Platinum

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## Products Affected

- ASSURE PLATINUM

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Assure Pro Test

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## Products Affected

- ASSURE PRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# At Last Test

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## Products Affected

- AT LAST TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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 Hypertension or Heart failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR HYPERTENSION: 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. FOR HEART FAILURE: A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, 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

## Products Affected

- ATACAND ORAL TABLET 32 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Hypertension or Heart failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR HYPERTENSION: 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. FOR HEART FAILURE: A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, candesartan
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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
Notes/References	
Revision Date	Prior Authorization: September 10, 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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
QL Criteria	2 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Atelvia

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## Products Affected

- ATELVIA

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

# Atorvastatin Calcium

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## Products Affected

- *atorvastatin calcium oral*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	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
<b>Notes/References</b>	
<b>Revision Date</b>	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 each of two preferred alternatives indicated for the members 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

# Aubagio

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## Products Affected

- AUBAGIO

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

# Aubra

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## Products Affected

- AUBRA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Avandamet

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## Products Affected

- AVANDAMET

PA Criteria	Criteria Details
Covered Uses	Diabetes
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%
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
Notes/ References	
Revision Date	Prior Authorization: September 03, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avandaryl

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## Products Affected

- AVANDARYL

PA Criteria	Criteria Details
Covered Uses	Diabetes
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%
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
Notes/ References	
Revision Date	Prior Authorization: September 03, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avandia

## Products Affected

- AVANDIA

PA Criteria	Criteria Details
Covered Uses	Diabetes
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%
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
Notes/ References	
Revision Date	Prior Authorization: September 03, 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 Hypertension or Diabetic nephropathy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR HYPERTENSION: 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. FOR DIABETIC NEPHROPATHY: 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.
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 24, 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 Hypertension or Diabetic nephropathy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR HYPERTENSION: 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. FOR DIABETIC NEPHROPATHY: 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.
Notes/References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aviane

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## Products Affected

- AVIANE

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

# Avidoxy

## Products Affected

- *avidoxy*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA Covered Indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For ALL tetracyclines(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)(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)
<b>Age Restrictions</b>	less than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AVINza

## Products Affected

- AVINZA

PA Criteria	Criteria Details
<b>Covered Uses</b>	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented progression through the World Health Organization analgesic ladder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR</p> <p>Member is enrolled in a hospice program or meets hospice criteria OR</p> <p>Member's resident state or contract state is California and the member is terminally ill OR</p> <p>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)</p> <p>Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.</p> <p>*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)</p> <p>AND</p> <p>Documentation of one of the following: A documented diagnosis of moderate to severe chronic pain</p> <p>AND</p> <p>formal pain evaluation has been documented</p> <p>AND</p> <p>Other pain management regimens have been inadequate</p>



<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For coverage in females members:Member is NOT pregnantANDMember?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 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Axert

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## Products Affected

- AXERT

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

# Axiron

## Products Affected

- AXIRON

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	6 ML Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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

# AzaSite

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## Products Affected

- AZASITE

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

# Azilect

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## Products Affected

- AZILECT

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	A documented diagnosis of hypertension, ANDA 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, 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any two preferred alternatives 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

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## Products Affected

- AZULFIDINE

<b>ST Criteria</b>	Trial of ONE month of Apriso, Asacol, Asacol HD, Delzicol, Lialda, or Pentasa
<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Azulfidine EN-tabs

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## Products Affected

- AZULFIDINE EN-TABS

<b>ST Criteria</b>	Trial of ONE month of Apriso, Asacol, Asacol HD, Delzicol, Lialda, or Pentasa
<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Azurette

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## Products Affected

- AZURETTE

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

# Balsalazide Disodium

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## Products Affected

- *balsalazide disodium*

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

# Balziva

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## Products Affected

- BALZIVA

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

# Banzel

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## Products Affected

- BANZEL ORAL TABLET

<b>QL Criteria</b>	8 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Next Test

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## Products Affected

- BAYER CONTOUR NEXT TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bayer Contour Test

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## Products Affected

- BAYER CONTOUR TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# BD Test

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## Products Affected

- BD TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Beconase AQ

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## Products Affected

- BECONASE AQ

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

# Belsomra

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## Products Affected

- BELSOMRA

<b>ST Criteria</b>	Trial of 1 month of one generic alternative: zolpidem, zolpidem er, eszopiclone, zaleplon
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Benicar

## Products Affected

- BENICAR ORAL TABLET 20 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension, ANDA 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	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
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	A documented diagnosis of hypertension, ANDA 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	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
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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Benicar HCT

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Benzamycin

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## Products Affected

- BENZAMYCIN

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

# BenzamycinPak

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## Products Affected

- BENZAMYCINPAK

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



# BG Star Test

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## Products Affected

- BG STAR TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bicalutamide

## Products Affected

- *bicalutamide*

PA Criteria	Criteria Details
Covered Uses	Metastatic prostate cancer
Exclusion Criteria	
Required Medical Information	Female Members- A AND (B OR C)A. Member is NOT pregnantANDB. Documented diagnosis of hirsutism secondary to ovarian or adrenal dysfunction (for example, polycystic ovary syndrome, adrenal or ovarian tumor)ORC. Member's physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in female
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bimatoprost

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## Products Affected

- *bimatoprost ophthalmic*

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

# Binosto

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## Products Affected

- BINOSTO

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

# Bioscanner Glucose Test

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## Products Affected

- BIOSCANNER GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# BL Test Strip Pack

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## Products Affected

- *bl test strip pack*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Blephamide

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## Products Affected

- BLEPHAMIDE

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

# Blood Glucose Test

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## Products Affected

- *blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Boniva

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## Products Affected

- BONIVA ORAL

<b>QL Criteria</b>	1 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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	Step therapy
ST Criteria	FOR COPD: Trial of 1 month each of Symbicort AND Spiriva. FOR ASTHMA: Trial of 1 month each of Symbicort AND Dulera
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

# 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	Step therapy
ST Criteria	FOR COPD: Trial of 1 month each of Symbicort AND Spiriva. FOR 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

# Briellyn

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## Products Affected

- *briellyn*

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

# Brilinta

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## Products Affected

- BRILINTA

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

# Brilinta

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## Products Affected

- BRILINTA

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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
<b>Covered Uses</b>	menopause
<b>Exclusion Criteria</b>	Brisdelle is not indicated for the treatment of any psychiatric condition.
<b>Required Medical Information</b>	(1) A documented diagnosis of moderate to severe vasomotor symptoms associated with menopause, AND (2) 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 (3) A documented contraindication or intolerance or allergy to the preferred generic alternative, paroxetine
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of one month of generic paroxetine
<b>Notes/References</b>	
<b>Revision Date</b>	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 Ostructive 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 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Budeprion SR

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## Products Affected

- BUDEPRION SR

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

# Budeprion XL

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## Products Affected

- BUDEPRION XL

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

# Budesonide

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## Products Affected

- *budesonide inhalation suspension 1 mg/2ml*

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

# Budesonide ER

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## Products Affected

- *budesonide er*

<b>QL Criteria</b>	3 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>ST Criteria</b>	Trial of ONE month of buprenorphine-naloxone sublingual tablet
<b>QL Criteria</b>	3 films Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bunavail

## Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>ST Criteria</b>	Trial of ONE month of buprenorphine-naloxone sublingual tablet
<b>QL Criteria</b>	6 films Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Bunavail

## Products Affected

- BUNAVAIL BUCCAL FILM 6.3-1 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>ST Criteria</b>	Trial of ONE month of buprenorphine-naloxone sublingual tablet
<b>QL Criteria</b>	2 films Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>QL Criteria</b>	24 tab Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 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
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>QL Criteria</b>	8 tab Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>QL Criteria</b>	90 tab Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# BuPROPion HCl

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## Products Affected

- *bupropion hcl oral*

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

# BuPROPion HCl ER (Smoking Det)

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## Products Affected

- *bupropion hcl er (smoking det)*

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

## BuPROPion HCl ER (SR)

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### Products Affected

- *bupropion hcl er (sr)*

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

## BuPROPion HCl ER (XL)

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### Products Affected

- *bupropion hcl er (xl)*

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

# Butorphanol Tartrate

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## Products Affected

- *butorphanol tartrate nasal*

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

# Butrans

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## Products Affected

- BUTRANS TRANSDERMAL PATCH  
WEEKLY 15 MCG/HR, 20 MCG/HR, 5  
MCG/HR, 10 MCG/HR

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

# Butrans

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## Products Affected

- BUTRANS TRANSDERMAL PATCH  
WEEKLY 7.5 MCG/HR

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



# Bydureon

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## Products Affected

- BYDUREON

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

# Bydureon

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## Products Affected

- BYDUREON

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

# Byetta 10 MCG Pen

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## Products Affected

- BYETTA 10 MCG PEN

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

# Byetta 5 MCG Pen

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## Products Affected

- BYETTA 5 MCG PEN

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

## Calcitonin (Salmon)

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### Products Affected

- *calcitonin (salmon)*

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

# Cambia

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## Products Affected

- CAMBIA

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

# Camila

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## Products Affected

- CAMILA

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

# Camrese

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## Products Affected

- CAMRESE

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



# Camrese Lo

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## Products Affected

- CAMRESE LO

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

# Canasa

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## Products Affected

- CANASA

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

# Candesartan Cilexetil

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## Products Affected

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

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

# Candesartan Cilexetil-HCTZ

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## Products Affected

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

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

# Caprelsa

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## Products Affected

- CAPRELSA

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

# CareOne Blood Glucose Test

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## Products Affected

- CAREONE BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# CareSens N Glucose Test

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## Products Affected

- CARESENS N GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Casodex

## Products Affected

- CASODEX

PA Criteria	Criteria Details
Covered Uses	Metastatic prostate cancer
Exclusion Criteria	
Required Medical Information	Female Members- A AND (B OR C)A. Member is NOT pregnantANDB. Documented diagnosis of hirsutism secondary to ovarian or adrenal dysfunction (for example, polycystic ovary syndrome, adrenal or ovarian tumor)ORC. Member's physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in female
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Caziant

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## Products Affected

- CAZIAN T

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

# CeleBREX

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## Products Affected

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

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

# CeleBREX

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## Products Affected

- CELEBREX ORAL CAPSULE 200 MG

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

# Celecoxib

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## Products Affected

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

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

# Celecoxib

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## Products Affected

- *celecoxib oral capsule 200 mg*

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

# CeleXA

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## Products Affected

- CELEXA

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

# Cenestin

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## Products Affected

- CENESTIN ORAL TABLET 0.45 MG, 0.625 MG, 0.9 MG, 0.3 MG

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

# Cerdelga

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## Products Affected

- CERDELGA

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



# Cesamet

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## Products Affected

- CESAMET

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

# Cesia

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## Products Affected

- CESIA

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

# Chantix

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## Products Affected

- CHANTIX

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

# Chantix Continuing Month Pak

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## Products Affected

- CHANTIX CONTINUING MONTH PAK

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

# Chantix Starting Month Pak

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## Products Affected

- CHANTIX STARTING MONTH PAK

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

# Chateal

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## Products Affected

- CHATEAL

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

# Chloroquine Phosphate

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## Products Affected

- *chloroquine phosphate oral*

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

# Choice DM Fora G20 Test Strips

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## Products Affected

- CHOICE DM FORA G20 TEST STRIPS

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Ciclodan

## Products Affected

- CICLODAN EXTERNAL SOLUTION

PA Criteria	Criteria Details
<b>Covered Uses</b>	Onychomycosis due to dermatophyte
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) 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, (2) 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 toenail infections), 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 (3) Member is NOT receiving a systemic (oral) antifungal agent - terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy applies
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ciclopirox

## Products Affected

- *ciclopirox external solution*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Onychomycosis due to dermatophyte
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) 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, (2) 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 toenail infections), 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 (3) Member is NOT receiving a systemic (oral) antifungal agent - terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy applies
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ciloxan

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## Products Affected

- CILOXAN OPHTHALMIC SOLUTION

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

# Cipro

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Infection
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
<b>Age Restrictions</b>	less than 10 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	^ 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.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cipro HC

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## Products Affected

- CIPRO HC

<b>QL Criteria</b>	2 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Infection
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
Age Restrictions	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

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## Products Affected

- CIPRODEX

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

# Ciprofloxacin HCl

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## Products Affected

- *ciprofloxacin hcl ophthalmic*

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Infection
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
<b>Age Restrictions</b>	less than 10 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	^ 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.
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Infection
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
<b>Age Restrictions</b>	less than 10 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	^ 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.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Citalopram Hydrobromide

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## Products Affected

- *citalopram hydrobromide oral tablet*

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

# Claravis

## Products Affected

- CLARAVIS

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	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 recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clarinet

## 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 ANDA 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 Clarinet 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	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/References	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Clarinet

## 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 ANDA 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 $\neq$ 2 years of age - For Clarinet 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	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	10 ml Per 1 Day
Notes/References	

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

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Clarinet-D 12 Hour

## Products Affected

- CLARINEX-D 12 HOUR

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 ANDA 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 $\neq$ 2 years of age - For Clarinet 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	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	2 tab Per 1 Day
Notes/References	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Clarinet-D 24 Hour

## Products Affected

- CLARINEX-D 24 HOUR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ANDA 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 Clarinet 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Clever Chek Auto-Code Test

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## Products Affected

- CLEVER CHEK AUTO-CODE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clever Chek Auto-Code Voice

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## Products Affected

- CLEVER CHEK AUTO-CODE VOICE IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Clever Chek Test

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## Products Affected

- CLEVER CHEK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clever Choice Auto-Code Test

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## Products Affected

- CLEVER CHOICE AUTO-CODE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Clever Choice Micro Test

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## Products Affected

- CLEVER CHOICE MICRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Climara

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## Products Affected

- CLIMARA

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

# Climara Pro

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## Products Affected

- CLIMARA PRO

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

# Clobex

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## Products Affected

- CLOBEX

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

# CloNIDine HCl ER

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## Products Affected

- *clonidine hcl er*

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

# Clopidogrel Bisulfate

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## Products Affected

- *clopidogrel bisulfate oral tablet 75 mg*

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



# CloZAPine

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## Products Affected

- *clozapine oral tablet 50 mg, 25 mg*

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

# CloZAPine

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## Products Affected

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

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

# CloZAPine

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## Products Affected

- *clozapine oral tablet 100 mg*

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

# CloZAPine

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## Products Affected

- *clozapine oral tablet dispersible 150 mg*

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

# Clozaril

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## Products Affected

- CLOZARIL ORAL TABLET 100 MG

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

# Clozaril

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## Products Affected

- CLOZARIL ORAL TABLET 25 MG

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

# Coartem

## Products Affected

- COARTEM

PA Criteria	Criteria Details
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	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
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Colazal

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## Products Affected

- COLAZAL

<b>ST Criteria</b>	Trial of ONE month of Apriso, Asacol, Asacol HD, Delzicol, Lialda, or Pentasa
<b>QL Criteria</b>	9 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Colcrlys

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## Products Affected

- COLCRYS

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

# Coly-Mycin S

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## Products Affected

- COLY-MYCIN S

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

# CombiPatch

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## Products Affected

- COMBIPATCH

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

# Combivir

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## Products Affected

- COMBIVIR

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

## Cometriq (100 mg Daily Dose)

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### Products Affected

- COMETRIQ (100 MG DAILY DOSE)

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

## Cometriq (140 mg Daily Dose)

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### Products Affected

- COMETRIQ (140 MG DAILY DOSE)

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

## Cometriq (60 mg Daily Dose)

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### Products Affected

- COMETRIQ (60 MG DAILY DOSE)

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ 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



# Concerta

## Products Affected

- CONCERTA ORAL TABLET  
EXTENDEDRELEASE\* 54 MG, 18 MG, 27  
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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

# Control AST

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## Products Affected

- CONTROL AST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Control Test

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## Products Affected

- CONTROL TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ConZip

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## Products Affected

- CONZIP

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

# Corlanor

## Products Affected

- CORLANOR

PA Criteria	Criteria Details
<b>Covered Uses</b>	FDA labeled use for heart failure (see required medical information section)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of stable, symptomatic chronic heart failure with left ventricular ejection fraction $\geq$ 35%, who are in sinus rhythm with resting heart rate $\leq$ 70 beats per minute AND are on maximally tolerated doses of beta-blockers (bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate/metoprolol succinate-HCTZ, nebivolol) OR have a documented contraindication to beta-blocker use.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Have a documented trial of one month of one of the following: ACE Inhibitor or ACE Inhibitor/HCTZ combination or Angiotensin-Receptor Blocker or Angiotensin-Receptor Blocker/HCTZ combination
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cortisporin

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## Products Affected

- CORTISPORIN OTIC

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

# Cortisporin-TC

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## Products Affected

- CORTISPORIN-TC

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

# Cozaar

## Products Affected

- COZAAR ORAL TABLET 50 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Hypertension ANDA 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 ANDA 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	FOR HYPERTENSION: 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. FOR DIABETIC NEPHROPATHY: 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.
QL Criteria	2 tab Per 1 Day
Notes/References	



<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Crestor

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## Products Affected

- CRESTOR

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

# Cryselle-28

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## Products Affected

- CRYSELLE-28

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

# Cutivate

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## Products Affected

- CUTIVATE

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

# CVS Blood Glucose Test

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## Products Affected

- *cvs blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cyclafem 1/35

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## Products Affected

- CYCLAFEM 1/35

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

# Cyclafem 7/7/7

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## Products Affected

- CYCLAFEM 7/7/7

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Major depressive disorder (MDD), Diabetic peripheral neuropathic pain (DPN), Generalized anxiety disorder (GAD), Fibromyalgia, Chronic musculoskeletal pain due to osteoarthritis, Chronic musculoskeletal pain due to chronic low back pain
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For coverage of additional quantities: 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 OR, for Cymbalta 120 mg dosing: Member has a diagnosis of Diabetic Peripheral Neuropathy (DPN), Major Depressive Disorder (MDD), or General Anxiety Disorder (GAD). For Cymbalta or duloxetine 60mg strength, 60 capsules in 30 days are allowed. For Cymbalta 90 mg dosing, Member has a diagnosis of Diabetic Peripheral Neuropathy (DPN), Major Depressive Disorder (MDD), or General Anxiety Disorder (GAD). For Cymbalta or duloxetine 30mg strength, 90 capsules in 30 days are allowed.
<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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



# Cymbalta

## Products Affected

- CYMBALTA ORAL CAPSULE DELAYED  
RELEASE PARTICLES 60 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Major depressive disorder (MDD), Diabetic peripheral neuropathic pain (DPN), Generalized anxiety disorder (GAD), Fibromyalgia, Chronic musculoskeletal pain due to osteoarthritis, Chronic musculoskeletal pain due to chronic low back pain
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For coverage of additional quantities: 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 OR, for Cymbalta 120 mg dosing: Member has a diagnosis of Diabetic Peripheral Neuropathy (DPN), Major Depressive Disorder (MDD), or General Anxiety Disorder (GAD). For Cymbalta or duloxetine 60mg strength, 60 capsules in 30 days are allowed. For Cymbalta 90 mg dosing, Member has a diagnosis of Diabetic Peripheral Neuropathy (DPN), Major Depressive Disorder (MDD), or General Anxiety Disorder (GAD). For Cymbalta or duloxetine 30mg strength, 90 capsules in 30 days are allowed.
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Daklinza

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## Products Affected

- DAKLINZA

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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 ANDA 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	
Notes/References	
Revision Date	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Daraprim

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## Products Affected

- DARAPRIM

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

# Dasetta 1/35

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## Products Affected

- DASETTA 1/35

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

# Dasetta 7/7/7

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## Products Affected

- DASETTA 7/7/7

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

# Daysee

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## Products Affected

- DAYSEE

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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



# DDAVP

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## Products Affected

- DDAVP NASAL
- DDAVP ORAL

<b>ST Criteria</b>	For Brand DDAVP Nasal Spray, Injection and Tablets: Trial of one month of generic desmopressin
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Delzicol

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## Products Affected

- DELZICOL

<b>QL Criteria</b>	12 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	All FDA Covered Indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For ALL tetracyclines(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)(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)
<b>Age Restrictions</b>	less than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Depo-Provera

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## Products Affected

- DEPO-PROVERA INTRAMUSCULAR\*  
SUSPENSION 150 MG/ML

<b>QL Criteria</b>	4 vials Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Depo-SubQ Provera 104

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## Products Affected

- DEPO-SUBQ PROVERA 104

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

# Desloratadine

## Products Affected

- *desloratadine*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ANDA 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 $\neq$ 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Desogestrel-Ethinyl Estradiol

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## Products Affected

- *desogestrel-ethinyl estradiol*

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



# Desonate

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## Products Affected

- DESONATE

<b>ST Criteria</b>	Trial of two weeks of generic desonide: any dosage form
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

# Detrol

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## Products Affected

- DETROL

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Detrol LA

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## Products Affected

- DETROL LA

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

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## Products Affected

- DEXILANT

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

# Dexmethylphenidate HCl

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## Products Affected

- *dexmethylphenidate hcl*

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

# Dexmethylphenidate HCl ER

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## Products Affected

- *dexmethylphenidate hcl er*

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



# Dexmethylphenidate HCl ER

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## Products Affected

- *dexmethylphenidate hcl er*

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
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

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## Products Affected

- *dextroamphetamine sulfate oral solution*

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

# Dextroamphetamine Sulfate ER

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## Products Affected

- *dextroamphetamine sulfate er*

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

# Diabetic.com Test

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## Products Affected

- *diabetic.com test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Diastat AcuDial

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## Products Affected

- DIASTAT ACUDIAL

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

# Diastat Pediatric

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## Products Affected

- DIASTAT PEDIATRIC

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

# DiaTrue Plus Test

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## Products Affected

- *diatruue plus test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Diclegis

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## Products Affected

- DICLEGIS

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

# Diclofenac Sodium

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## Products Affected

- *diclofenac sodium ophthalmic*

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

# Differin

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## Products Affected

- DIFFERIN EXTERNAL LOTION
- DIFFERIN EXTERNAL 0.1 %
- DIFFERIN EXTERNAL CREAM

<b>ST Criteria</b>	Trial of one month of generic adapalene cream or gel 0.1%
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dificid

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## Products Affected

- DIFICID

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

# Diffucan

## Products Affected

- DIFLUCAN ORAL TABLET 200 MG, 100 MG, 50 MG
- DIFLUCAN ORAL SUSPENSION RECONSTITUTED

PA Criteria	Criteria Details
<b>Covered Uses</b>	Bone marrow transplant - Candidiasis: Prophylaxis Candidal vulvovaginitis Candidiasis Cryptococcal meningitis Oropharyngeal candidiasis
<b>Exclusion Criteria</b>	Diffucan 150mg not included
<b>Required Medical Information</b>	A documented diagnosis of 1 of the below indications & specified criteria ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of generic fluconazole (if request is for brand Diffucan) 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 ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 1 topical antifungal AND oral terbinafine Fungal Otitis externa ANDA 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 ANDA 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 ANDA 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) ANDA 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) ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic itraconazole
<b>Age Restrictions</b>	

PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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:</p> <p>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)</p>
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 13, 2015  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Diovan

## Products Affected

- DIOVAN ORAL TABLET 320 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Hypertension or Heart failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR HYPERTENSION: 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. FOR HEART FAILURE: A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, candesartan
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 40 MG, 160 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Hypertension or Heart failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	FOR HYPERTENSION: 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. FOR HEART FAILURE: A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, 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 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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Diovan HCT

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dipentum

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## Products Affected

- DIPENTUM

<b>ST Criteria</b>	Trial of ONE month of Apriso, Asacol, Asacol HD, Delzicol, Lialda, or Pentasa
<b>QL Criteria</b>	4 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Discount Drug Mart Test

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## Products Affected

- *discount drug mart test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ditropan XL

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## Products Affected

- DITROPAN XL

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dolophine

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## Products Affected

- DOLOPHINE ORAL TABLET 5 MG

<b>QL Criteria</b>	180 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For ALL tetracyclines(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)(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)
Age Restrictions	less 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

# Doxycycline Hyclate

## Products Affected

- *doxycycline hyclate oral tablet delayed release*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA Covered Indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For ALL tetracyclines(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)(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)
<b>Age Restrictions</b>	less than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Doxycycline Monohydrate

## Products Affected

- *doxycycline monohydrate*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA Covered Indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For ALL tetracyclines(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)(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)
<b>Age Restrictions</b>	less than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dronabinol

## Products Affected

- *dronabinol*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Chemotherapy-induced nausea and vomiting
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: Nausea and vomiting associated with cancer chemotherapy following previous failure of ondansetron or granisetron OR Anorexia associated with weight loss in patients with AIDS following failure (one month trial) of megestrol or oxandrolone
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Drospirenone-Ethinyl Estradiol

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## Products Affected

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

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

# Drug Emporium Test

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## Products Affected

- *drug emporium test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duac

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## Products Affected

- DUAC

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

# Duane Reade Test

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## Products Affected

- *duane reade test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Duavee

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## Products Affected

- DUAVEE

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

# Duetact

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## Products Affected

- DUETACT

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

# Duexis

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## Products Affected

- DUEXIS

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

# Dulera

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## Products Affected

- DULERA

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

# DULoxetine HCl

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## Products Affected

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

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

# DULoxetine HCl

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## Products Affected

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

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

# DULoxetine HCl

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## Products Affected

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

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

# Duo-Care Test

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## Products Affected

- DUO-CARE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Duragesic-100

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

# Dutasteride

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## Products Affected

- *dutasteride*

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

# Easy Plus Blood Glucose Test

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## Products Affected

- *easy plus blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Plus II Glucose Test

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## Products Affected

- *easy plus ii glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Easy Step Test

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## Products Affected

- EASY STEP TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Talk Blood Glucose Test

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## Products Affected

- *easy talk blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Touch Test

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## Products Affected

- EASY TOUCH TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Easy Trak Blood Glucose Test

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## Products Affected

- *easy trak blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyGluco

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## Products Affected

- EASYGLUCO IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyMax 15 Test

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## Products Affected

- EASYMAX 15 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EASYMax Test

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## Products Affected

- EASYMAX TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyPlus Blood Glucose Test

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## Products Affected

- *easyplus blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# EasyPRO Blood Glucose Test

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## Products Affected

- EASYPRO BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EasyPRO Plus

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## Products Affected

- EASYPRO PLUS IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Eclipse Test

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## Products Affected

- ECLIPSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Edarbi

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## Products Affected

- EDARBI

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

# Edarbyclor

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## Products Affected

- EDARBYCLOR

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

# Edluar

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## Products Affected

- EDLUAR

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

# Effexor XR

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## Products Affected

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

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

# Effexor XR

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## Products Affected

- EFFEXOR XR ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 150 MG

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



# Effient

## Products Affected

- EFFIENT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI]) managed by percutaneous coronary intervention (PCI)
<b>Exclusion Criteria</b>	History of Stroke or TIA
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Element Compact Test

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## Products Affected

- *element compact test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Element Plus Test

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## Products Affected

- ELEMENT PLUS TEST

<b>QL Criteria</b>	300 strips Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Element Test

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## Products Affected

- ELEMENT TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Elestrin

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## Products Affected

- ELESTRIN

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

# Elidel

## Products Affected

- ELIDEL

PA Criteria	Criteria Details
<b>Covered Uses</b>	atopic dermatitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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, ORA documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient?s condition, ORTreatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Face, genital area: 3 months, Other body areas: 6 months, Patients less than 2 yrs : 3 months
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Elinest

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## Products Affected

- ELINEST

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

# Eliquis

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## Products Affected

- ELIQUIS

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



# Ella

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## Products Affected

- ELLA

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

# Elmiron

## Products Affected

- ELMIRON

PA Criteria	Criteria Details
Covered Uses	interstitial cystitis.
Exclusion Criteria	
Required Medical Information	A documented diagnosis of interstitial cystitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
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
<b>Covered Uses</b>	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented progression through the World Health Organization analgesic ladder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR</p> <p>Member is enrolled in a hospice program or meets hospice criteria OR</p> <p>Member's resident state or contract state is California and the member is terminally ill OR</p> <p>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)</p> <p>Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.</p> <p>*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)</p> <p>AND</p> <p>Documentation of one of the following: A documented diagnosis of moderate to severe chronic pain</p> <p>AND</p> <p>formal pain evaluation has been documented</p> <p>AND</p> <p>Other pain management regimens have been inadequate</p>

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Embrace Blood Glucose Test

---

## Products Affected

- EMBRACE BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Embrace Evo Blood Glucose Test

---

## Products Affected

- EMBRACE EVO BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Embrace Pro Glucose Test

---

## Products Affected

- EMBRACE PRO GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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



# Emend

---

## Products Affected

- EMEND ORAL CAPSULE 80 & 125 MG

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

# Emend

---

## Products Affected

- EMEND ORAL CAPSULE 80 MG

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

# Emoquette

---

## Products Affected

- EMOQUETTE

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

# Emsam

---

## Products Affected

- EMSAM

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

# Enablex

---

## Products Affected

- ENABLEX

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Encare

---

## Products Affected

- ENCARE

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

# Enjuvia

---

## Products Affected

- ENJUVIA

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

# Enpresse-28

---

## Products Affected

- ENPRESSE-28

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



# Enskyce

---

## Products Affected

- ENSKYCE

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

# Entocort EC

---

## Products Affected

- ENTOCORT EC

<b>ST Criteria</b>	Trial of one month of generic budesonide SR
<b>QL Criteria</b>	3 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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: November 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Envision Autocode Test

---

## Products Affected

- ENVISION AUTOCODE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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), ANDMember 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

# EQL TRUEtest Test

---

## Products Affected

- EQL TRUETEST TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EQL TrueTrack Test

---

## Products Affected

- EQL TRUETRACK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Erivedge

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## Products Affected

- ERIVEDGE

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



# Errin

---

## Products Affected

- ERRIN

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

# Esbriet

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## Products Affected

- ESBRIET

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

# Escitalopram Oxalate

---

## Products Affected

- *escitalopram oxalate oral solution*

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

# Escitalopram Oxalate

---

## Products Affected

- *escitalopram oxalate oral tablet*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

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

# Esomeprazole Strontium

---

## Products Affected

- *esomeprazole strontium oral capsule delayed release 49.3 mg*

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

# Estarylla

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## Products Affected

- ESTARYLLA

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

# Estradiol

---

## Products Affected

- *estradiol transdermal patch weekly*

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



# Estrasorb

---

## Products Affected

- ESTRASORB

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

# Estrogel

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## Products Affected

- ESTROGEL

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

# Eszopiclone

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## Products Affected

- *eszopiclone*

<b>ST Criteria</b>	Trial of ONE month of a generic hypnotic, i.e., zolpidem, temazepam, triazolam
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Evamist

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## Products Affected

- EVAMIST

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

# Evekeo

## Products Affected

- EVEKEO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD) Narcolepsy Obesity (if benefit rider applies)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year (adhd/narcolepsy) 12 weeks (obesity)
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr,Strattera, OR Vyvanse
<b>QL Criteria</b>	120 tablets Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EvenCare + Blood Glucose Test

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## Products Affected

- EVENCARE + BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EvenCare Blood Glucose Test

---

## Products Affected

- EVENCARE BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# EvenCare G2 Test

---

## Products Affected

- EVENCARE G2 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# EvenCare G3 Test

---

## Products Affected

- EVENCARE G3 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Evolution Autocode

---

## Products Affected

- EVOLUTION AUTOCODE IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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

# ExacTech R-S-G Test

---

## Products Affected

- EXACTECH R-S-G TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ExacTech Test

---

## Products Affected

- EXACTECH TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exalgo

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## Products Affected

- EXALGO ORAL 12 MG, 8 MG

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	2 EA Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exalgo

---

## Products Affected

- EXALGO ORAL 16 MG

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	4 EA Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Exalgo

---

## Products Affected

- EXALGO ORAL 32 MG

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	2 tablets Per 1 day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Exforge

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## Products Affected

- EXFORGE

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

# Exforge HCT

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## Products Affected

- EXFORGE HCT

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

# Express Med Test Strip Pack

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## Products Affected

- *express med test strip pack*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ez Smart Blood Glucose Test

---

## Products Affected

- EZ SMART BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ez Smart Plus Glucose Test

---

## Products Affected

- EZ SMART PLUS GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fabior

---

## Products Affected

- FABIOR

<b>ST Criteria</b>	Trial of one month each of two preferred alternatives indicated for the members condition, one of which has to be tretinoin.
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Infection
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
Age Restrictions	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

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## Products Affected

- FALMINA

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



# Famciclovir

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## Products Affected

- *famciclovir oral tablet 125 mg, 250 mg*

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

# Famciclovir

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## Products Affected

- *famciclovir oral tablet 500 mg*

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

# Famvir

---

## Products Affected

- FAMVIR ORAL TABLET 500 MG

<b>QL Criteria</b>	21 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# Fanapt

---

## Products Affected

- FANAPT

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

# Fanapt Titration Pack

---

## Products Affected

- FANAPT TITRATION PACK

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

# Farxiga

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## Products Affected

- FARXIGA

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

# Farydak

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## Products Affected

- FARYDAK

<b>QL Criteria</b>	12 capsules Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
200 MG

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
100 MG

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
150 MG

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
25 MG

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

# FC Female Condom

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## Products Affected

- FC FEMALE CONDOM

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

# FC2 Female Condom

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## Products Affected

- FC2 FEMALE CONDOM

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

# FemCap

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## Products Affected

- FEMCAP

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



# Femhrt Low Dose

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## Products Affected

- FEMHRT LOW DOSE

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

# Femring

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## Products Affected

- FEMRING

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

# Fenoglide

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## Products Affected

- FENOGLIDE

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

# FentaNYL

---

## Products Affected

- *fentanyl*

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

# FentaNYL

---

## Products Affected

- *fentanyl*

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

# FentaNYL Citrate

## Products Affected

- *fentanyl citrate buccal*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Breakthrough cancer pain, General anesthesia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation 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</p>

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

<b>QL Criteria</b>	15 lollipops Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fentora

## Products Affected

- FENTORA

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer pain, General anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation 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</p>

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



<b>ST Criteria</b>	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)
<b>QL Criteria</b>	15 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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

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

# 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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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 dayss
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fexmid

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## Products Affected

- FEXMID

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

# Fibricor

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## Products Affected

- FIBRICOR

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

# Fifty50 Glucose Test 2.0

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## Products Affected

- FIFTY50 GLUCOSE TEST 2.0

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Flector

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## Products Affected

- FLECTOR

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

# Flomax

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## Products Affected

- FLOMAX

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



# Flonase

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## Products Affected

- FLONASE

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

# Fluconazole

## Products Affected

- *fluconazole oral suspension reconstituted*
- *fluconazole oral tablet 100 mg, 200 mg, 50 mg*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Bone marrow transplant - Candidiasis: Prophylaxis Candidal vulvovaginitis Candidiasis Cryptococcal meningitis Oropharyngeal candidiasis
<b>Exclusion Criteria</b>	Diflucan 150mg not included
<b>Required Medical Information</b>	A documented diagnosis of 1 of the below indications & specified criteria ANDA 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 ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 1 topical antifungal AND oral terbinafine Fungal Otitis externa ANDA 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 ANDA 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 ANDA 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) ANDA 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) ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic itraconazole
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

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

PA Criteria	Criteria Details
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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:</p> <p>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)</p>
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 13, 2015  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# FLUoxetine HCl

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## Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

# FLUoxetine HCl

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## Products Affected

- *fluoxetine hcl oral capsule 40 mg*

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

# FLUoxetine HCl

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## Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

# FLUoxetine HCl

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## Products Affected

- *fluoxetine hcl oral solution*

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

# FLUoxetine HCl

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## Products Affected

- *fluoxetine hcl oral tablet 10 mg, 60 mg*

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



# FLUoxetine HCl

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## Products Affected

- *fluoxetine hcl oral capsule 10 mg*

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

# FLUoxetine HCl

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## Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

# Flurbiprofen Sodium

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## Products Affected

- *flurbiprofen sodium*

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

# Fluvastatin Sodium

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## Products Affected

- *fluvastatin sodium*

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

# Fluvastatin Sodium ER

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## Products Affected

- *fluvastatin sodium er*

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

# FluvoxaMINE Maleate

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## Products Affected

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

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

# FluvoxaMINE Maleate

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## Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

# FluvoxaMINE Maleate ER

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## Products Affected

- *fluvoxamine maleate er*

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamylphenidate/ 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

# FORA D10 Blood Glucose Test

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## Products Affected

- FORA D10 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA D15C Blood Glucose Test

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## Products Affected

- FORA D15C BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA D15g Blood Glucose Test

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## Products Affected

- FORA D15G BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA D15z Blood Glucose Test

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## Products Affected

- FORA D15Z BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA D20 Blood Glucose Test

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## Products Affected

- FORA D20 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA G20 Blood Glucose Test

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## Products Affected

- FORA G20 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# FORA G30a Blood Glucose Test

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## Products Affected

- FORA G30A BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA G71a Blood Glucose Test

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## Products Affected

- FORA G71A BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA G90 Blood Glucose Test

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## Products Affected

- FORA G90 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fora GD20 Test

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## Products Affected

- FORA GD20 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V10 Blood Glucose Test

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## Products Affected

- FORA V10 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V12 Blood Glucose Test

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## Products Affected

- FORA V12 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V20 Blood Glucose Test

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## Products Affected

- FORA V20 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FORA V22 Blood Glucose Test

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## Products Affected

- FORA V22 BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# FORA V30a Blood Glucose Test

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## Products Affected

- FORA V30A BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ForaCare GD40 Test

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## Products Affected

- FORACARE GD40 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ForaCare premium V10 Test

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## Products Affected

- FORACARE PREMIUM V10 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ForaCare Test N Go Test

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## Products Affected

- FORACARE TEST N GO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Foradil Aerolizer

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## Products Affected

- FORADIL AEROLIZER

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

# Forfivo XL

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## Products Affected

- FORFIVO XL

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

# Fortesta

## Products Affected

- FORTESTA

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	4 GM Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Fosamax

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## Products Affected

- FOSAMAX

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



# Fosamax Plus D

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## Products Affected

- FOSAMAX PLUS D

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

# Fragmin

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## Products Affected

- FRAGMIN SUBCUTANEOUS\* SOLUTION  
95000 UNIT/3.8ML

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

# FreeStyle InsuLinx Test

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## Products Affected

- FREESTYLE INSULINX TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FreeStyle Lite Test

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## Products Affected

- FREESTYLE LITE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FreeStyle Test

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## Products Affected

- FREESTYLE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Frova

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## Products Affected

- FROVA

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

# Fulyzaq

## Products Affected

- FULYZAQ

PA Criteria	Criteria Details
Covered Uses	HIV infection
Exclusion Criteria	
Required Medical Information	A documented diagnosis of treatment of symptomatic relief of non-infectious diarrhea in adult patients with HIV/AIDS AND ALL of the following: (1)Currently stable on anti-retroviral therapy, (2)History of diarrhea for one month or more, (3)Diarrhea is documented to be persistent loose stools despite regular use of anti-diarrheal medication (ADM) (i.e., loperamide, diphenoxylate, bismuth subsalicylate) or one or more watery bowel movements per day without regular ADM use, (4)Negative GI culture or stool test for ALL of the following: bacteria, bacteria toxin, ova, parasites, or viruses, (5)No history of other GI diseases associated with diarrhea (i.e. ulcerative colitis, Crohn's disease, celiac sprue (gluten-enteropathy), chronic pancreatitis, malabsorption)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Fycompa

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## Products Affected

- FYCOMPA

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



# Gabapentin

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## Products Affected

- *gabapentin oral tablet*

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

# Gabapentin

---

## Products Affected

- *gabapentin oral capsule*

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

# Gabapentin

---

## Products Affected

- *gabapentin oral solution*

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

# Gabril

---

## Products Affected

- GABITRIL ORAL TABLET 12 MG, 4 MG

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

# Gabril

---

## Products Affected

- GABITRIL ORAL TABLET 2 MG

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

# Gabril

---

## Products Affected

- GABITRIL ORAL TABLET 16 MG

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

# Garamycin

---

## Products Affected

- GARAMYCIN OPHTHALMIC SOLUTION

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

# Gatifloxacin

---

## Products Affected

- *gatifloxacin*

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



# GE100 Blood Glucose Test

---

## Products Affected

- *ge100 blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gelnique

---

## Products Affected

- GELNIQUE

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gentamicin Sulfate

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## Products Affected

- *gentamicin sulfate ophthalmic solution*

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

# Geodon

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## Products Affected

- GEODON ORAL

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

# Giant Eagle Pharm Test

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## Products Affected

- *giant eagle pharm test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gianvi

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## Products Affected

- GIANVI

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

# Giazo

## Products Affected

- GIAZO

PA Criteria	Criteria Details
Covered Uses	Mild to moderate ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of mild to moderate ulcerative colitis in male patients 18 years and older
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Per Product Labeling, Giazo effectiveness was not demonstrated in female patients
ST Criteria	Trial of ONE month of Apriso, Asacol, Asacol HD, Delzicol, Lialda, or Pentasa
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

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## Products Affected

- GILDAGIA

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



# Gildess 1.5/30

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## Products Affected

- GILDESS 1.5/30

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

# Gildess 1/20

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## Products Affected

- GILDESS 1/20

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

## Gildess FE 1.5/30

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### Products Affected

- GILDESS FE 1.5/30

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

# Gildess FE 1/20

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## Products Affected

- GILDESS FE 1/20

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

# Gilenya

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## Products Affected

- GILENYA

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

# Gilotrif

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## Products Affected

- GILOTRIF

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

# Gleevec

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## Products Affected

- GLEEVEC

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

# Gluco Perfect 3 Test

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## Products Affected

- GLUCO PERFECT 3 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Glucocard 01 Sensor Plus

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## Products Affected

- GLUCOCARD 01 SENSOR PLUS

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glucocard Expression Test

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## Products Affected

- GLUCOCARD EXPRESSION TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glucocard Vital Test

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## Products Affected

- GLUCOCARD VITAL TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glucocard X-Sensor

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## Products Affected

- GLUCOCARD X-SENSOR

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# GlucoCom Test

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## Products Affected

- GLUCOCOM TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glucolab Test

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## Products Affected

- GLUCOLAB TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# GlucoNavii Blood Glucose Test

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## Products Affected

- GLUCONAVII BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glycate

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## Products Affected

- GLYCATE

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



# Glyxambi

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## Products Affected

- GLYXAMBI

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

# Gmate Blood Glucose Test

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## Products Affected

- GMATE BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Gralise

---

## Products Affected

- GRALISE ORAL TABLET 300 MG

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

# Gralise

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## Products Affected

- GRALISE ORAL TABLET 600 MG

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

# Gralise Starter

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## Products Affected

- GRALISE STARTER

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

# Granisetron HCl

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## Products Affected

- *granisetron hcl oral*

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

# Granisol

---

## Products Affected

- GRANISOL

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

# GuanFACINE HCl ER

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## Products Affected

- *guanfacine hcl er oral tablet extended release*  
*24 hr\* 1 mg*

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



# Harvoni

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## Products Affected

- HARVONI

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

# Health Alliance

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## Products Affected

- HEALTH ALLIANCE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Heather

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## Products Affected

- HEATHER

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

# Hycamtin

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## Products Affected

- HYCAMTIN ORAL

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

# Hydroxychloroquine Sulfate

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## Products Affected

- *hydroxychloroquine sulfate oral*

<b>QL Criteria</b>	30 days minimum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented progression through the World Health Organization analgesic ladder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR</p> <p>Member is enrolled in a hospice program or meets hospice criteria OR</p> <p>Member's resident state or contract state is California and the member is terminally ill OR</p> <p>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)</p> <p>Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.</p> <p>*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)</p> <p>AND</p> <p>Documentation of one of the following: A documented diagnosis of moderate to severe chronic pain</p> <p>AND</p> <p>formal pain evaluation has been documented</p> <p>AND</p> <p>Other pain management regimens have been inadequate</p>

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hyzaar

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
Notes/References	
Revision Date	Prior Authorization: September 10, 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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ibandronate Sodium

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## Products Affected

- *ibandronate sodium oral*

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

# Ibrance

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## Products Affected

- IBRANCE

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

# Iclusig

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## Products Affected

- ICLUSIG

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

# Ilevro

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## Products Affected

- ILEVRO

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

# Imbruvica

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## Products Affected

- IMBRUVICA

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

# Imiquimod

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## Products Affected

- *imiquimod external*

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

# Imitrex

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## Products Affected

- IMITREX ORAL

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



# Imitrex

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## Products Affected

- IMITREX SUBCUTANEOUS\*

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

# Imitrex

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## Products Affected

- IMITREX NASAL

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

# Implanon

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## Products Affected

- IMPLANON

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

# Incivek

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## Products Affected

- INCIVEK

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

# Incruse Ellipta

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## Products Affected

- INCRUSE ELLIPTA

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

# Inderal XL

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## Products Affected

- INDERAL XL

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

# Infinity Blood Glucose Test

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## Products Affected

- INFINITY BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Inlyta

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## Products Affected

- INLYTA

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



# Intermezzo

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## Products Affected

- INTERMEZZO

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

# Introvale

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## Products Affected

- INTROVALE

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Diagnosis required for 18 and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: Only members 18 and over are subject to diagnosis criteria.
ST Criteria	Trial of 14 days each of 3 of: clonidine/ sr, guanfacine, amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ 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

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## Products Affected

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

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

# Invega

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## Products Affected

- INVEGA ORAL TABLET EXTENDED  
RELEASE 24 HR\* 9 MG

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

# Invokamet

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## Products Affected

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

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

# Invokamet

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## Products Affected

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

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

# Invokana

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## Products Affected

- INVOKANA

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



# Irbesartan

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## Products Affected

- *irbesartan oral tablet 75 mg, 150 mg*

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

# Irbesartan-Hydrochlorothiazide

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## Products Affected

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

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

# Irenka

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## Products Affected

- IRENKA

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

# Iressa

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## Products Affected

- IRESSA

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

# Itraconazole

## Products Affected

- *itraconazole oral*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Aspergillosis, Invasive, salvage therapy Blastomycosis Candidiasis of the esophagus Histoplasmosis, Disseminated Onychomycosis due to dermatophyte Oropharyngeal candidiasis Pulmonary histoplasmosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)AspergillosisBlastomycosisTreatment of oropharyngeal/esophageal candidiasis in HIV-infected personsChromoblastomycosisCoccidioidomycosis associated with AIDS, treatment and prophylaxisCryptococcosisCryptococcal meningitis - HIV infectionCutaneous 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] ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of one topical antifungal AND preferred generic oral terbinafineFebrile neutropeniaHistoplasmosisPenicillium marneffeii infectionProphylaxis of invasive fungal infections in persons with Chronic Granulomatous Disease, hematologic malignancies or liver transplantsDisseminated microsporidiosis caused by Trachipleistophora or Brachiola species in HIV-infected personsOnychomycosis (Tinea unguium) due to dermatophyte ANDA 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)ANDA 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 diseaseFungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection)ParacoccidioidomycosisSporotrichosisTinea versicolorTinea capitis AND A documented contraindication/intolerance/allergy/failure of two weeks of generic terbinafineVulvovaginal Candidiasis
<b>Age Restrictions</b>	

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

# Jakafi

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## Products Affected

- JAKAFI

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For coverage in females members:Member is NOT pregnantANDMember?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 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Janumet

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## Products Affected

- JANUMET

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

# Janumet XR

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## Products Affected

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

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

# Janumet XR

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## Products Affected

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

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

# Januvia

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## Products Affected

- JANUVIA

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

# Jardiance

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## Products Affected

- JARDIANCE

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

# Jencycla

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## Products Affected

- JENCYCLA

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

# Jentaduetto

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## Products Affected

- JENTADUETO

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

# Jolessa

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## Products Affected

- JOLESSA

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



# Jolivette

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## Products Affected

- JOLIVETTE

<b>QL Criteria</b>	1.5 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	(1) 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, (2) 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 toenail infections), 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 (3) 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	Step therapy applies
Notes/References	
Revision Date	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Junel 1.5/30

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## Products Affected

- JUNEL 1.5/30

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

# Junel 1/20

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## Products Affected

- JUNEL 1/20

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

# Junel FE 1.5/30

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## Products Affected

- JUNEL FE 1.5/30

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

# Junel FE 1/20

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## Products Affected

- JUNEL FE 1/20

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

# Juxtapid

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## Products Affected

- JUXTAPID ORAL CAPSULE 10 MG

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

# Juxtapid

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## Products Affected

- JUXTAPID ORAL CAPSULE 20 MG

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



# Juxtapid

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## Products Affected

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

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

# Juxtapid

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## Products Affected

- JUXTAPID ORAL CAPSULE 5 MG

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

# Kadian

## Products Affected

- KADIAN

PA Criteria	Criteria Details
<b>Covered Uses</b>	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented progression through the World Health Organization analgesic ladder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR</p> <p>Member is enrolled in a hospice program or meets hospice criteria OR</p> <p>Member's resident state or contract state is California and the member is terminally ill OR</p> <p>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)</p> <p>Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.</p> <p>*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)</p> <p>AND</p> <p>Documentation of one of the following: A documented diagnosis of moderate to severe chronic pain</p> <p>AND</p> <p>formal pain evaluation has been documented</p> <p>AND</p> <p>Other pain management regimens have been inadequate</p>

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	60 caps Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kalydeco

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## Products Affected

- KALYDECO

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

# Kalydeco

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## Products Affected

- KALYDECO

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Diagnosis required for 18 and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: Only members 18 and over are subject to diagnosis criteria.
ST Criteria	Trial of 14 days each of 3 of: clonidine/ sr, guanfacine, amphetamine/dextroamphetamine/ sr, dexamylphenidate/ 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

# Karbinal ER

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## Products Affected

- KARBINAL ER

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



# Kariva

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## Products Affected

- KARIVA

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

# Kazano

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## Products Affected

- KAZANO

<b>ST Criteria</b>	Trial of one month each of Jentadueto AND Kombiglyze XR AND Janumet OR Janumet XR.
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kelnor 1/35

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## Products Affected

- KELNOR 1/35

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

# Keppra XR

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## Products Affected

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

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

# Keppra XR

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## Products Affected

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

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

# Kerr Drug Test Strip Pack

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## Products Affected

- *kerr drug test strip pack*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kerydin

## Products Affected

- KERYDIN

PA Criteria	Criteria Details
Covered Uses	Onychomycosis due to dermatophyte
Exclusion Criteria	
Required Medical Information	(1) 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, (2) 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 toenail infections), 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 (3) 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	Step therapy applies
Notes/References	
Revision Date	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ketorolac Tromethamine

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## Products Affected

- *ketorolac tromethamine ophthalmic*

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



# Ketorolac Tromethamine

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## Products Affected

- *ketorolac tromethamine oral*

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

# Keveyis

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## Products Affected

- KEVEYIS

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

# Khedeza

## 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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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

# Kinray Test

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## Products Affected

- *kinray test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kombiglyze XR

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## Products Affected

- KOMBIGLYZE XR

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

# Korlym

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## Products Affected

- KORLYM

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

# Kroger Blood Glucose Test

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## Products Affected

- *kroger blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kroger Premium Glucose Test

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## Products Affected

- *kroger premium glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Kroger Test

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## Products Affected

- *kroger test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kurvelo

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## Products Affected

- KURVELO

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

# LaMICtal ODT

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## Products Affected

- LAMICTAL ODT ORAL TABLET  
DISPERSIBLE 50 MG

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

# LaMICtal ODT

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## Products Affected

- LAMICTAL ODT ORAL TABLET  
DISPERSIBLE 200 MG, 100 MG

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

# LaMICtal ODT

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## Products Affected

- LAMICTAL ODT ORAL TABLET  
DISPERSIBLE 25 MG

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

# LaMICtal XR

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## Products Affected

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

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

# LaMICtal XR

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## Products Affected

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

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

# LaMICtal XR

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## Products Affected

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

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



# LamISIL

## Products Affected

- LAMISIL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Cutaneous leishmaniasis Cutaneous sporotrichosis Paracoccidioidomycosis Seborrheic dermatitis Tinea capitis Onychomycosis (Tinea unguium)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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] ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of one topical antifungalCutaneous leishmaniasisCutaneous sporotrichosis Paracoccidioidomycosis Seborrheic dermatitisTinea capitisOnychomycosis (Tinea unguium) due to dermatophyte ANDA 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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LamoTRigine

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## Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

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

# LamoTRigine

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## Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

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

# LamoTRigine

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## Products Affected

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

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

# LamoTRIGine ER

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## Products Affected

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

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

# LamoTRIGine ER

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## Products Affected

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

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

# LamoTRIGine ER

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## Products Affected

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

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

# Lansoprazole

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## Products Affected

- *lansoprazole oral capsule delayed release 30 mg*

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



# Larin 1/20

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## Products Affected

- LARIN 1/20

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

# Larin Fe 1.5/30

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## Products Affected

- LARIN FE 1.5/30

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

# Larin Fe 1/20

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## Products Affected

- LARIN FE 1/20

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

# Latanoprost

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## Products Affected

- *latanoprost ophthalmic*

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

# Latuda

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## Products Affected

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

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

# Latuda

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## Products Affected

- LATUDA ORAL TABLET 80 MG

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

# Lazanda

## Products Affected

- LAZANDA

PA Criteria	Criteria Details
<b>Covered Uses</b>	Breakthrough cancer pain, General anesthesia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation 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</p>

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

<b>ST Criteria</b>	Trial of one week of generic fentanyl transmucosal lozenge
<b>QL Criteria</b>	4 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Leena

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## Products Affected

- LEENA

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

# Leflunomide

## Products Affected

- *leflunomide oral*

PA Criteria	Criteria Details
Covered Uses	rheumatoid arthritis, psoriatic arthritis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of rheumatoid arthritis OR a documented diagnosis of psoriatic arthritis AND a negative pregnancy test for females of childbearing age within the last 14 days, unless it is documented that the member is sterile (e.g. hysterectomy, unable to achieve pregnancy) or in menopause
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: September 03, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lemtrada

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## Products Affected

- LEMTRADA

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

# Lenvima 10 MG Daily Dose

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## Products Affected

- LENVIMA 10 MG DAILY DOSE

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

# Lenvima 14 MG Daily Dose

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## Products Affected

- LENVIMA 14 MG DAILY DOSE

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

# Lenvima 20 MG Daily Dose

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## Products Affected

- LENVIMA 20 MG DAILY DOSE

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

# Lenvima 24 MG Daily Dose

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## Products Affected

- LENVIMA 24 MG DAILY DOSE

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

# Lescol

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## Products Affected

- LESCOLO

<b>ST Criteria</b>	Trial of ONE generic statin: atorvastatin, fluvastatin, lovastatin, pravastatin, or simvastatin
<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Lescol XL

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## Products Affected

- LESCOL XL

<b>ST Criteria</b>	Trial of ONE generic statin: atorvastatin, fluvastatin, lovastatin, pravastatin, or simvastatin
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lessina

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## Products Affected

- LESSINA

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

# Levaquin

## Products Affected

- LEVAQUIN ORAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Infection
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
<b>Age Restrictions</b>	less than 10 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	^ 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.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# LevETIRAcetam ER

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## Products Affected

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

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

# LevETIRAcetam ER

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## Products Affected

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

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ANDA 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Levocetirizine Dihydrochloride

## Products Affected

- *levocetirizine dihydrochloride oral solution*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ANDA 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>QL Criteria</b>	10 ml Per 1 Day
<b>Notes/References</b>	

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



<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Levofloxacin

## Products Affected

- *levofloxacin oral*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Infection
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
<b>Age Restrictions</b>	less than 10 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	^ 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.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Levonest

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## Products Affected

- LEVONEST

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

# Levonorgest-Eth Estrad 91-Day

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## Products Affected

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

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

# Levonorgestrel

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## Products Affected

- *levonorgestrel oral tablet 0.75 mg*

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

# Levonorgestrel-Ethinyl Estrad

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## Products Affected

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

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

# Levonorgestrel-Ethinyl Estrad

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## Products Affected

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

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

## Levora 0.15/30 (28)

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### Products Affected

- LEVORA 0.15/30 (28)

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



# Lexapro

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## Products Affected

- LEXAPRO ORAL TABLET

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

# Lexapro

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## Products Affected

- LEXAPRO ORAL SOLUTION

<b>ST Criteria</b>	trial of one month of the drug's preferred generic equivalent alternative escitalopram
<b>QL Criteria</b>	20 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lialda

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## Products Affected

- LIALDA

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

# Liberty Next Generation Test

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## Products Affected

- LIBERTY NEXT GENERATION TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Liberty Test

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## Products Affected

- *liberty test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lidoderm

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## 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

# Life Medical Test

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## Products Affected

- *life medical test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Linzess

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## Products Affected

- LINZESS

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



# Lipitor

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## Products Affected

- LIPITOR

<b>ST Criteria</b>	Trial of ONE generic statin: atorvastatin, fluvastatin, lovastatin, pravastatin, or simvastatin
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lipofen

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## Products Affected

- LIPOFEN

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

# Liptruzet

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## Products Affected

- LIPTRUZET

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

# Livalo

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## Products Affected

- LIVALO

<b>ST Criteria</b>	Trial of ONE generic statin: atorvastatin, fluvastatin, lovastatin, pravastatin, or simvastatin
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Locoid

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## Products Affected

- LOCOID

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

# Locoid Lipocream

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## Products Affected

- LOCOID LIPOCREAM

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

# Lofibra

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## Products Affected

- LOFIBRA

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

# Long Test

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## Products Affected

- *long test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Lonsurf

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## Products Affected

- LONSURF ORAL TABLET 15-6.14 MG

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

# Lonsurf

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## Products Affected

- LONSURF ORAL TABLET 20-8.19 MG

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

# Lopid

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## Products Affected

- LOPID

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

# Loryna

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## Products Affected

- LORYNA

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

# Losartan Potassium

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## Products Affected

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

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

# Losartan Potassium-HCTZ

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## Products Affected

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

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

# LoSeasonique

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## Products Affected

- LOSEASONIQUE

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

# Lotrel

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## Products Affected

- LOTREL

<b>ST Criteria</b>	Trial of ONE month of generic equivalent amlodipine/benazepril
<b>Notes/ References</b>	
<b>Revision Date</b>	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	(1) A female patient with a diagnosis of severe* irritable bowel syndrome (IBS) with primary symptom of diarrhea with chronic IBS symptoms (generally lasting 6 months or longer), and (2) anatomic or biochemical abnormalities of the gastrointestinal tract have been excluded, and (3) failure of response to at least one conventional therapy agent for at least one month
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	*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.
Notes/References	
Revision Date	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lovastatin

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## Products Affected

- *lovastatin*

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

# Lovaza

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## Products Affected

- LOVAZA

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

# Low-Ogestrel

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## Products Affected

- LOW-OGESTREL

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

# Lumigan

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## Products Affected

- LUMIGAN OPHTHALMIC SOLUTION 0.01  
%

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

# Lunesta

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## Products Affected

- LUNESTA

<b>ST Criteria</b>	Trial of ONE month of a generic hypnotic, i.e., zolpidem, temazepam, triazolam
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lutera

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## Products Affected

- LUTERA

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

# Luvox CR

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## Products Affected

- LUVOX CR

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



# Luxiq

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## Products Affected

- LUXIQ

<b>ST Criteria</b>	Trial of two weeks of a preferred generic betamethasone alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lynparza

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## Products Affected

- LYNPARZA

<b>QL Criteria</b>	480 capsules Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lysteda

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## Products Affected

- LYSTEDA

<b>ST Criteria</b>	Trial of ONE month of generic tranexamic acid
<b>QL Criteria</b>	30 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Lyza

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## Products Affected

- LYZA

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

# Makena

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## Products Affected

- MAKENA

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

# Malarone

## Products Affected

- MALARONE

PA Criteria	Criteria Details
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	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
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Marinol

## Products Affected

- MARINOL

PA Criteria	Criteria Details
Covered Uses	Chemotherapy-induced nausea and vomiting
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: Nausea and vomiting associated with cancer chemotherapy following previous failure of ondansetron or granisetron OR Anorexia associated with weight loss in patients with AIDS following failure (one month trial) of megestrol or oxandrolone
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

# Marlissa

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## Products Affected

- *marlissa*

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



# Maxalt

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## Products Affected

- MAXALT

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

# Maxalt-MLT

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## Products Affected

- MAXALT-MLT

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

# Maxima Blood Glucose Test

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## Products Affected

- MAXIMA BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Maxitrol

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## Products Affected

- MAXITROL OPHTHALMIC SUSPENSION

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

# MedroxyPROGESTERone Acetate

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## Products Affected

- *medroxyprogesterone acetate intramuscular\**

<b>QL Criteria</b>	1 vial Per 90 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	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
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Meijer Blood Glucose Test

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## Products Affected

- *meijer blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Meijer Premium Glucose Test

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## Products Affected

- *meijer premium glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Meijer Test

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## Products Affected

- *meijer test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Meijer TRUEtest Test

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## Products Affected

- MEIJER TRUETEST TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Meijer TRUEtrack Test

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## Products Affected

- MEIJER TRUETRACK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Mekinist

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## Products Affected

- MEKINIST

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

# Menostar

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## Products Affected

- MENOSTAR

<b>QL Criteria</b>	1 patch Per 7 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

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## Products Affected

- METADATE ER

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

# Methadone HCl

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## Products Affected

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

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



# Methadose

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## Products Affected

- METHADOSE ORAL TABLET SOLUBLE
- METHADOSE ORAL TABLET

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

# Methamphetamine HCl

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## Products Affected

- *methamphetamine hcl*

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

# 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

# Methylphenidate HCl

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## Products Affected

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

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

# Methylphenidate HCl

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## Products Affected

- *methylphenidate hcl oral tablet*

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

# Methylphenidate HCl

---

## Products Affected

- *methylphenidate hcl oral tablet chewable*

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



# Methylphenidate HCl

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## Products Affected

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

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

# Methylphenidate HCl ER

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## Products Affected

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

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

# Methylphenidate HCl ER

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## Products Affected

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

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

# Methylphenidate HCl ER

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## Products Affected

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

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

# Methylphenidate HCl ER (CD)

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## Products Affected

- *methylphenidate hcl er (cd)*

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

# Methylphenidate HCl ER (LA)

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## Products Affected

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

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

# Methylphenidate HCl ER (LA)

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## Products Affected

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

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

# Mevacor

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## Products Affected

- MEVACOR

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



# Miacalcin

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## Products Affected

- MIACALCIN NASAL

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

# Microdot Test

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## Products Affected

- MICRODOT TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Microgestin 1.5/30

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## Products Affected

- MICROGESTIN 1.5/30

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

# Microgestin 1/20

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## Products Affected

- MICROGESTIN 1/20

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

# Microgestin FE 1.5/30

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## Products Affected

- MICROGESTIN FE 1.5/30

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

# Microgestin FE 1/20

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## Products Affected

- MICROGESTIN FE 1/20

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

# Migranal

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## Products Affected

- MIGRANAL

<b>ST Criteria</b>	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
<b>QL Criteria</b>	1 box Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Mimvey

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## Products Affected

- MIMVEY

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



# Minivelle

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## Products Affected

- MINIVELLE

<b>QL Criteria</b>	8 patches Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Minocycline HCl ER

## Products Affected

- *minocycline hcl er*

PA Criteria	Criteria Details
Covered Uses	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For ALL tetracyclines(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)(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)
Age Restrictions	less 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

# Mirapex ER

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## Products Affected

- MIRAPEX ER

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

# Mirena

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## Products Affected

- MIRENA

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

# Mirtazapine

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## Products Affected

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

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

# Mirvaso

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## Products Affected

- MIRVASO

<b>ST Criteria</b>	Trial of one month each of topical metronidazole AND sulfacetamide sodium with sulfur
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Mitigare

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## Products Affected

- MITIGARE

<b>ST Criteria</b>	Trial of 1 month of COLCRYS
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Modafinil

## Products Affected

- *modafinil*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation OROSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following:Member is currently using an oral/dental applianceMember has undergone an uvulopalatopharyngoplasty (UPPP)Member is greater than or equal to 65 yrs of ageMember has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following:Member is compliant with and currently using CPAP/BiPAP treatmentMember is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Monodox

## Products Affected

- MONODOX ORAL CAPSULE 100 MG, 75 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Mono-Linyah

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## Products Affected

- MONO-LINYAH

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

# MonoNessa

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## Products Affected

- MONONESSA

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

# Montelukast Sodium

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## Products Affected

- *montelukast sodium oral*

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

# Montelukast Sodium

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## Products Affected

- *montelukast sodium oral*

<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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## Products Affected

- MOXEZA

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

# MS Contin

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## Products Affected

- MS CONTIN

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

# MyGlucoHealth Test

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## Products Affected

- MYGLUCOHEALTH TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	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 recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Myzilra

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## Products Affected

- MYZILRA

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

# Naratriptan HCl

---

## Products Affected

- *naratriptan hcl*

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

# Natacyn

---

## Products Affected

- NATACYN

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



# Natesto

## Products Affected

- NATESTO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	3 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Natpara

---

## Products Affected

- NATPARA

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

# Navarro Blood Glucose Test

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## Products Affected

- NAVARRO BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Necon 0.5/35 (28)

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### Products Affected

- NECON 0.5/35 (28)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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)

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

# Necon 7/7/7

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## Products Affected

- NECON 7/7/7

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

# Nefazodone HCl

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## Products Affected

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

<b>ST Criteria</b>	Trial of one month of one of: budeprion SR/XL, bupropion/SR/XL, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine/sr, mirtazapine, selfemra, sertraline, venlafaxine, venlafaxine er tablet, venlafaxine sr cap
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

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

# Neomycin-Polymyxin-Gramicidin

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## Products Affected

- *neomycin-polymyxin-gramicidin*

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

<b>QL Criteria</b>	2 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

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

# Neosporin

---

## Products Affected

- NEOSPORIN

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

# Nesina

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## Products Affected

- NESINA

<b>ST Criteria</b>	Trial of one month each of two preferred brand products (Januvia, Onglyza, Tradjenta).
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neupro

---

## Products Affected

- NEUPRO

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

# Neurontin

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## Products Affected

- NEURONTIN ORAL CAPSULE

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



# Neurontin

---

## Products Affected

- NEURONTIN ORAL TABLET

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

# Neutek 2Tek Test

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## Products Affected

- NEUTEK 2TEK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nevanac

---

## Products Affected

- NEVANAC

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

# NexAVAR

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## Products Affected

- NEXAVAR

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

# NexGen Test

---

## Products Affected

- NEXGEN TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NexIUM

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## Products Affected

- NEXIUM ORAL PACKET

<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# Nexplanon

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## Products Affected

- NEXPLANON

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



# Next Choice

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## Products Affected

- NEXT CHOICE

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

# Next Choice One Dose

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## Products Affected

- NEXT CHOICE ONE DOSE

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

# Nicoderm CQ

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## Products Affected

- NICODERM CQ

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

# Nicorette

---

## Products Affected

- NICORETTE MOUTH/THROAT GUM

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

# Nicorette

---

## Products Affected

- NICORETTE MOUTH/THROAT LOZENGE

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

# Nicorette Mini

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## Products Affected

- NICORETTE MINI

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

# Nicotine

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## Products Affected

- *nicotine*

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

# Nicotine Polacrilex

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## Products Affected

- *nicotine polacrilex mouth/throat*

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



# Nicotrol

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## Products Affected

- NICOTROL

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

# Nicotrol NS

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## Products Affected

- NICOTROL NS

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

# Nora-BE

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## Products Affected

- NORA-BE

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

# Norethindrone

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## Products Affected

- *norethindrone oral*

<b>QL Criteria</b>	1.5 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

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

# Norgestimate-Eth Estradiol

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## Products Affected

- *norgestimate-eth estradiol*

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

# Norgestim-Eth Estrad Triphasic

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## Products Affected

- *norgestim-eth estrad triphasic*

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

# Norgestrel-Ethinyl Estradiol

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## Products Affected

- *norgestrel-ethinyl estradiol*

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Infection
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
Age Restrictions	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

# Nor-QD

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## Products Affected

- NOR-QD

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

# Northera

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## Products Affected

- NORTHERA ORAL CAPSULE 100 MG

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

# Northera

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## Products Affected

- NORTHERA ORAL CAPSULE 200 MG, 300 MG

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

# Nortrel 0.5/35 (28)

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## Products Affected

- NORTREL 0.5/35 (28)

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

# Nortrel 1/35 (21)

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## Products Affected

- NORTREL 1/35 (21)

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

# Nortrel 1/35 (28)

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## Products Affected

- NORTREL 1/35 (28)

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

# Nortrel 7/7/7

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## Products Affected

- NORTREL 7/7/7

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



# Norvasc

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## Products Affected

- NORVASC

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

# Nova Max Glucose Test

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## Products Affected

- NOVA MAX GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN 70/30

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## Products Affected

- NOVOLIN 70/30

<b>ST Criteria</b>	Trial of one month of the preferred alternative Humulin product (i.e. Humulin, Humulin N, Humulin R, Humulin 70/30)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN 70/30 ReliOn

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## Products Affected

- NOVOLIN 70/30 RELION

<b>ST Criteria</b>	Trial of one month of the preferred alternative Humulin product (i.e. Humulin, Humulin N, Humulin R, Humulin 70/30)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN N

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## Products Affected

- NOVOLIN N

<b>ST Criteria</b>	Trial of one month of the preferred alternative Humulin product (i.e. Humulin, Humulin N, Humulin R, Humulin 70/30)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN N ReliOn

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## Products Affected

- NOVOLIN N RELION

<b>ST Criteria</b>	Trial of one month of the preferred alternative Humulin product (i.e. Humulin, Humulin N, Humulin R, Humulin 70/30)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN R

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## Products Affected

- NOVOLIN R

<b>ST Criteria</b>	Trial of one month of the preferred alternative Humulin product (i.e. Humulin, Humulin N, Humulin R, Humulin 70/30)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NovoLIN R ReliOn

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## Products Affected

- NOVOLIN R RELION

<b>ST Criteria</b>	Trial of one month of the preferred alternative Humulin product (i.e. Humulin, Humulin N, Humulin R, Humulin 70/30)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Nucynta

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## Products Affected

- NUCYNTA

<b>ST Criteria</b>	Trial of 2 days of immediate release oxycodone or morphine
<b>QL Criteria</b>	180 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nucynta ER

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## Products Affected

- NUCYNTA ER

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

# Nuedexta

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## Products Affected

- NUEDEXTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Pseudobulbar affect
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of pseudobulbar affect
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NuvaRing

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## Products Affected

- NUVARING

<b>QL Criteria</b>	1 EA Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
Exclusion Criteria	
Required Medical Information	Narcolepsy, confirmed by sleep lab evaluation OROSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following:Member is currently using an oral/dental applianceMember has undergone an uvulopalatopharyngoplasty (UPPP)Member is greater than or equal to 65 yrs of ageMember has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following:Member is compliant with and currently using CPAP/BiPAP treatmentMember is experiencing excessive sleepiness despite CPAP/BiPAP use
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 150 MG, 250 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation (OSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following: Member is currently using an oral/dental appliance Member has undergone an uvulopalatopharyngoplasty (UPPP) Member is greater than or equal to 65 yrs of age Member has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following: Member is compliant with and currently using CPAP/BiPAP treatment Member is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation (OSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following: Member is currently using an oral/dental appliance Member has undergone an uvulopalatopharyngoplasty (UPPP) Member is greater than or equal to 65 yrs of age Member has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following: Member is compliant with and currently using CPAP/BiPAP treatment Member is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nymalize

## Products Affected

- NYMALIZE

PA Criteria	Criteria Details
Covered Uses	Subarachnoid hemorrhage
Exclusion Criteria	
Required Medical Information	A documented diagnosis of subarachnoid hemorrhage (SAH) in adults AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one week of the preferred generic alternative, nimodipine ORMember is unable to tolerate oral capsule or tablet
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	21 days
Other Criteria	
ST Criteria	A documented trial of one week of the preferred generic alternative, nimodipine
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

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## Products Affected

- OCELLA

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

# Ocufen

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## Products Affected

- OCUFEN

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

# Ocuflox

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## Products Affected

- OCUFLOX

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

# Odomzo

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## Products Affected

- ODOMZO

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

# Ofev

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## Products Affected

- OFEV

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

# Ofloxacin

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## Products Affected

- *ofloxacin ophthalmic*

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

# Ofloxacin

---

## Products Affected

- *ofloxacin otic*

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

# Ofloxacin

## Products Affected

- *ofloxacin oral*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Infection
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
<b>Age Restrictions</b>	less than 10 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	^ 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.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# OLANZapine

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## Products Affected

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

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

# OLANZapine

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## Products Affected

- *olanzapine oral tablet 2.5 mg*

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

# OLANZapine-FLUOxetine HCl

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## Products Affected

- *olanzapine-fluoxetine hcl*

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

# Olux

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## Products Affected

- OLUX

<b>ST Criteria</b>	Trial of Two weeks of a generic clobetasol alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Olux-E

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## Products Affected

- OLUX-E

<b>ST Criteria</b>	Trial of Two weeks of a generic clobetasol alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Omega-3-acid Ethyl Esters

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## Products Affected

- *omega-3-acid ethyl esters*

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

# Omeprazole

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## Products Affected

- *omeprazole oral capsule delayed release 10 mg, 40 mg*

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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



# Omniflex Diaphragm

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## Products Affected

- OMNIFLEX DIAPHRAGM

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

# On Call Express Blood Glucose

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## Products Affected

- ON CALL EXPRESS BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# On Call Plus Blood Glucose

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## Products Affected

- ON CALL PLUS BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# On Call Vivid Blood Glucose

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## Products Affected

- ON CALL VIVID BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ondansetron

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## Products Affected

- *ondansetron*

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

# Ondansetron

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## Products Affected

- *ondansetron*

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

# Ondansetron HCl

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## Products Affected

- *ondansetron hcl oral tablet 24 mg*

<b>QL Criteria</b>	5 tablets Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ondansetron HCl

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## Products Affected

- *ondansetron hcl oral tablet 4 mg, 8 mg*

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



# Ondansetron HCl

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## Products Affected

- *ondansetron hcl oral solution*

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

# OneTouch Test

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## Products Affected

- ONETOUCH TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OneTouch Ultra Blue

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## Products Affected

- ONETOUCH ULTRA BLUE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OneTouch Verio

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## Products Affected

- ONETOUCH VERIO IN VITRO STRIP

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onexton

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## Products Affected

- ONEXTON

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

# Onfi

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## Products Affected

- ONFI ORAL TABLET 10 MG, 20 MG

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

# Onglyza

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## Products Affected

- ONGLYZA

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

# Onmel

## Products Affected

- ONMEL

PA Criteria	Criteria Details
<b>Covered Uses</b>	onychomycosis (Tinea unguium)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Opana ER

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## Products Affected

- OPANA ER ORAL

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

# Opsumit

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## Products Affected

- OPSUMIT

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

# Options Conceptrol

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## Products Affected

- OPTIONS CONCEPTROL

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

# Options Gynol II Contraceptive

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## Products Affected

- OPTIONS GYNOL II CONTRACEPTIVE

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

# Optium Test

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## Products Affected

- OPTIUM TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OptiumEZ Test

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## Products Affected

- OPTIUMEZ TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OptumRx Blood Glucose Test

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## Products Affected

- OPTUMRX BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oracea

## Products Affected

- ORACEA

PA Criteria	Criteria Details
<b>Covered Uses</b>	Rosacea
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of Rosacea, ANDAge greater than 8 years old, ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of fourteen days of the preferred alternative topical metronidazole OR generic doxycycline
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Oravig

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## Products Affected

- ORAVIG

<b>QL Criteria</b>	14 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orkambi

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## Products Affected

- ORKAMBI

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

# Orsythia

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## Products Affected

- ORSYTHIA

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

# Ortho Diaphragm Coil

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## Products Affected

- ORTHO DIAPHRAGM COIL

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

# Ortho Diaphragm Flat

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## Products Affected

- ORTHO DIAPHRAGM FLAT

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

# Ortho Evra

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## Products Affected

- ORTHO EVRA

<b>QL Criteria</b>	12 packages Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ortho Micronor

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## Products Affected

- ORTHO MICRONOR

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

# Oseni

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## Products Affected

- OSENI

<b>ST Criteria</b>	Trial of one month of pioglitazone in combination with two preferred brand products (Januvia, Onglyza, Tradjenta).
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Oxtellar XR

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## Products Affected

- OXTELLAR XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 150 MG, 300  
MG

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

# Oxtellar XR

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## Products Affected

- OXTELLAR XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 600 MG

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

# OxyCODONE HCl ER

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## Products Affected

- *oxycodone hcl er*

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

# Oxycodone-Ibuprofen

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## Products Affected

- *oxycodone-ibuprofen*

<b>QL Criteria</b>	28 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OxyCONTIN

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## Products Affected

- OXYCONTIN

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

# Oxymorphone HCl ER

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## Products Affected

- *oxymorphone hcl er*

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

# Paliperidone ER

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## Products Affected

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

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

# Paliperidone ER

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## Products Affected

- *paliperidone er oral tablet extended release 24 hr\* 9 mg*

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



# Pantoprazole Sodium

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## Products Affected

- *pantoprazole sodium oral*

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

# Paragard Intrauterine Copper

---

## Products Affected

- PARAGARD INTRAUTERINE COPPER

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

# PARoxetine HCl

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## Products Affected

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

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

# PARoxetine HCl

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## Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 mg*

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

# PARoxetine HCl ER

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## Products Affected

- *paroxetine hcl er*

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

# Patanol

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## Products Affected

- PATANOL

<b>ST Criteria</b>	Trial of one week of Pataday
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Paxil

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## Products Affected

- PAXIL ORAL TABLET 20 MG, 10 MG

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

# Paxil

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## Products Affected

- PAXIL ORAL TABLET 30 MG, 40 MG

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



# Paxil

---

## Products Affected

- PAXIL ORAL SUSPENSION

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

# Paxil CR

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## Products Affected

- PAXIL CR

<b>ST Criteria</b>	Trial of ONEmonth of generic alternative, paroxetine SR
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Penlac

## Products Affected

- PENLAC

PA Criteria	Criteria Details
<b>Covered Uses</b>	Onychomycosis due to dermatophyte
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) 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, (2) 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 toenail infections), 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 (3) Member is NOT receiving a systemic (oral) antifungal agent - terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy applies
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pennsaid

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## Products Affected

- PENNSAID TRANSDERMAL SOLUTION  
1.5 %

<b>ST Criteria</b>	Trial of 1 month of Voltaren Gel
<b>QL Criteria</b>	15 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pennsaid

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## Products Affected

- PENNSAID TRANSDERMAL SOLUTION 2  
%

<b>ST Criteria</b>	Trial of 1 month of Voltaren Gel
<b>QL Criteria</b>	4 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pentasa

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## Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE\* 250 MG

<b>QL Criteria</b>	16 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pentasa

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## Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE\* 500 MG

<b>QL Criteria</b>	8 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Perforomist

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## Products Affected

- PERFOROMIST

<b>ST Criteria</b>	Trial of 1 month each of Foradil AND Serevent
<b>QL Criteria</b>	60 vials (120ml) Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Pertzye

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## Products Affected

- PERTZYE

<b>ST Criteria</b>	Trial of two weeks of two preferred alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pexeva

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## Products Affected

- PEXEVA ORAL TABLET 10 MG, 20 MG

<b>ST Criteria</b>	Trial of paroxetine (NSO)
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pexeva

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## Products Affected

- PEXEVA ORAL TABLET 40 MG, 30 MG

<b>ST Criteria</b>	Trial of paroxetine (NSO)
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pharmacist Choice Autocode

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## Products Affected

- PHARMACIST CHOICE AUTOCODE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Philith

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## Products Affected

- PHILITH

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

# Picato

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## Products Affected

- PICATO

<b>QL Criteria</b>	1 tube Per 60 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pimtrea

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## Products Affected

- PIMTREA

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

# Pirmella 1/35

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## Products Affected

- PIRMELLA 1/35

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



# Pirmella 7/7/7

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## Products Affected

- PIRMELLA 7/7/7

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

# Plaquenil

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## Products Affected

- PLAQUENIL

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

# Plavix

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## Products Affected

- PLAVIX ORAL TABLET 75 MG

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

# Plegridy

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## Products Affected

- PLEGRIDY

<b>QL Criteria</b>	1 ML Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Plegridy Starter Pack

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## Products Affected

- PLEGRIDY STARTER PACK

<b>QL Criteria</b>	1 ML Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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



# PocketChem EZ Test

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## Products Affected

- POCKETCHEM EZ TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Polymyxin B-Trimethoprim

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## Products Affected

- *polymyxin b-trimethoprim*

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

# Polytrim

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## Products Affected

- POLYTRIM

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

# Pomalyst

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## Products Affected

- POMALYST

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

# Portia-28

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## Products Affected

- PORTIA-28

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

# Potiga

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## Products Affected

- POTIGA ORAL TABLET 200 MG, 300 MG, 400 MG

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

# Pradaxa

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## Products Affected

- PRADAXA

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

# Praluent

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## Products Affected

- PRALUENT

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



# Pramipexole Dihydrochloride ER

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## Products Affected

- *pramipexole dihydrochloride er oral tablet  
extended release 24 hr\* 4.5 mg*

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

# Prandin

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## Products Affected

- PRANDIN

<b>ST Criteria</b>	Trial of ONE month of generic repaglinide
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pravachol

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## Products Affected

- PRAVACHOL

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

# Pravastatin Sodium

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## Products Affected

- *pravastatin sodium*

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

# Precision PCx

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## Products Affected

- PRECISION PCX

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision PCX Plus Test

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## Products Affected

- PRECISION PCX PLUS TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision Point of Care Test

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## Products Affected

- PRECISION POINT OF CARE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision QID Test

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## Products Affected

- PRECISION QID TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Precision Sof-Tact Test

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## Products Affected

- PRECISION SOF-TACT TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision Xtra Blood Glucose

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## Products Affected

- PRECISION XTRA BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pred-G

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## Products Affected

- PRED-G

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

# Prefest

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## Products Affected

- PREFEST

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

# Prentif Cavity-Rim Cerv Cap

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## Products Affected

- PRENTIF CAVITY-RIM CERV CAP

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

# Prentif Fitting Set

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## Products Affected

- PRENTIF FITTING SET

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

# Prestige Smart System Test

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## Products Affected

- *prestige smart system test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prestige Test

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## Products Affected

- PRESTIGE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Prestige Value Pack

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## Products Affected

- PRESTIGE VALUE PACK

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
<b>Exclusion Criteria</b>	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prevacid SoluTab

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## Products Affected

- PREVACID SOLUTAB

PA Criteria	Criteria Details
<b>Covered Uses</b>	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
<b>Exclusion Criteria</b>	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

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

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Previfem

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## Products Affected

- PREVIFEM

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



# PriLOSEC

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## Products Affected

- PRILOSEC ORAL CAPSULE DELAYED RELEASE

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

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

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PriLOSEC

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## Products Affected

- PRILOSEC ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	2 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PriLOSEC OTC

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## Products Affected

- PRILOSEC OTC

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>Notes/ References</b>	
<b>Revision Date</b>	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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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

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## Products Affected

- PROAIR HFA

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

# ProAir RespiClick

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## Products Affected

- PROAIR RESPICLICK

<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

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## Products Affected

- PROCYSBI ORAL CAPSULE DELAYED  
RELEASE 25 MG

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

# Procysbi

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## Products Affected

- PROCYSBI ORAL CAPSULE DELAYED  
RELEASE 75 MG

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

# Prodigy AutoCode Blood Glucose

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## Products Affected

- PRODIGY AUTOCODE BLOOD GLUCOSE  
IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prodigy No Coding Blood Gluc

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## Products Affected

- PRODIGY NO CODING BLOOD GLUC

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Promethazine HCl

## Products Affected

- *promethazine hcl oral*
- *promethazine hcl suppository 12.5 mg, 25 mg*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and PhenerganB AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeineA. Member is less than 2 years of ageORB. Member is less than 6 years of ageANDC. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert6 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
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promethazine-Codeine

## Products Affected

- *promethazine-codeine*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and PhenerganB AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeineA. Member is less than 2 years of ageORB. Member is less than 6 years of ageANDC. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert6 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
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promethazine-DM

## Products Affected

- *promethazine-dm*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ORB. 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert 6 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
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promethegan

## Products Affected

- PROMETHEGAN

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ORB. Member is less than 6 years of age ANDC. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert 6 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
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Protonix

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## Products Affected

- PROTONIX ORAL

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

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

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Protonix

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## Products Affected

- PROTONIX ORAL

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).



PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 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	?16 FOR 0.1%
Prescriber Restrictions	
Coverage Duration	Face, genital area: 3 months, Other body areas: 6 months, Patients less than 2 yrs : 3 months
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Proventil HFA

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## Products Affected

- PROVENTIL HFA

<b>ST Criteria</b>	Trial of 1 week each of Ventolin HFA AND Proair
<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Provigil

## Products Affected

- PROVIGIL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation (ROSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following: Member is currently using an oral/dental appliance Member has undergone an uvulopalatopharyngoplasty (UPPP) Member is greater than or equal to 65 yrs of age Member has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following: Member is compliant with and currently using CPAP/BiPAP treatment Member is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PROzac

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## Products Affected

- PROZAC ORAL CAPSULE 40 MG

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

# PROzac

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## Products Affected

- PROZAC ORAL CAPSULE 20 MG

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

# PROzac

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## Products Affected

- PROZAC ORAL CAPSULE 10 MG

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



# PROzac Weekly

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## Products Affected

- PROZAC WEEKLY

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

# PTS Panels Glucose Test

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## Products Affected

- PTS PANELS GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pulmicort Flexhaler

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## Products Affected

- PULMICORT FLEXHALER

<b>ST Criteria</b>	Trial of 1 month of Asmanex, Qvar, or Flovent/HFA
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Qualaquin

---

## Products Affected

- QUALAQUIN

<b>QL Criteria</b>	42 caps Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Quasense

---

## Products Affected

- QUASENSE

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

# Qudexy XR

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## Products Affected

- QUDEXY XR

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

# QUetiapine Fumarate

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## Products Affected

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

<b>QL Criteria</b>	3 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

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



# QUetiapine Fumarate

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## Products Affected

- *quetiapine fumarate oral tablet 200 mg*

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

# QUetiapine Fumarate

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## Products Affected

- *quetiapine fumarate oral tablet 25 mg*

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

# QuickTek Test

---

## Products Affected

- QUICKTEK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

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## Products Affected

- *quinine sulfate oral*

<b>QL Criteria</b>	42 caps Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Quintet AC Blood Glucose Test

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## Products Affected

- QUINTET AC BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Quintet Blood Glucose Test

---

## Products Affected

- QUINTET BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RA TRUEtest Test

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## Products Affected

- RA TRUETEST TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# RABEprazole Sodium

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## Products Affected

- *rabeprazole sodium*

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

# Ranexa

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## Products Affected

- RANEXA ORAL TABLET EXTENDED  
RELEASE 12 HR\* 1000 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# Rapaflo

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## Products Affected

- RAPAFLU

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 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rayos

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## Products Affected

- RAYOS

<b>ST Criteria</b>	Trial of prednisone
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Reclast

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## Products Affected

- RECLAST

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

# Reclipsen

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## Products Affected

- RECLIPSEN

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

# RefuAH Plus Blood Glucose Test

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## Products Affected

- REFUAH PLUS BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Relenza Diskhaler

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## Products Affected

- RELENZA DISKHALER

<b>QL Criteria</b>	2 EA Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Blood Glucose Test

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## Products Affected

- RELION BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Confirm/micro Test

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## Products Affected

- RELION CONFIRM/MICRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Prime Test

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## Products Affected

- RELION PRIME TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Ultima Test

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## Products Affected

- RELION ULTIMA TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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, ANDA documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), ANDMember is receiving palliative care, ANDConcomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), ANDTrial 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

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

# 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, ANDA documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), ANDMember is receiving palliative care, ANDConcomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), ANDTrial 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  
12 MG/0.6ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid-induced constipation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of opioid-induced constipation, ANDA 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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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).
<b>QL Criteria</b>	10 vial Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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



# Relpax

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## Products Affected

- RELPAX

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

# Remeron

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## Products Affected

- REMERON

<b>ST Criteria</b>	Trial of one month of generic mirtazapine OR mirtazapine ODT
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Remeron SolTab

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## Products Affected

- REMERON SOLTAB

<b>ST Criteria</b>	Trial of one month of generic mirtazapine OR mirtazapine ODT
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Repatha

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## Products Affected

- REPATHA

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

# Repatha SureClick

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## Products Affected

- REPATHA SURECLICK

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

# Requip XL

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## Products Affected

- REQUIP XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 6 MG, 8 MG, 4 MG, 2 MG

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

# Requip XL

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## Products Affected

- REQUIP XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 12 MG

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

# Rescula

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## Products Affected

- RESCULA

<b>ST Criteria</b>	Trial of 1 week of latanoprost AND Travatan Z
<b>QL Criteria</b>	1 (5ml) bottle Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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 tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple 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 each of two preferred alternatives indicated for the members 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

# 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 tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple 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

# Retin-A Micro Pump

## Products Affected

- RETIN-A MICRO PUMP EXTERNAL 0.1 %, 0.04 %

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

# Revatio

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## Products Affected

- REVATIO ORAL SUSPENSION  
RECONSTITUTED

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

# Revatio

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## Products Affected

- REVATIO ORAL TABLET

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

# Reveal Blood Glucose Test

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## Products Affected

- REVEAL BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rexall Blood Glucose Test

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## Products Affected

- REXALL BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rexulti

## Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder, Schizophrenia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of Major depressive disorder or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, member must meet additional precertification requirements.
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Rhinocort Aqua

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## Products Affected

- RHINOCORT AQUA

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

# Riax

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## Products Affected

- RIAx

<b>ST Criteria</b>	Trial of one month of generic benzoyl peroxide foam
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS100 Blood Glucose

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## Products Affected

- RIGHTEST GS100 BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS300 Blood Glucose

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## Products Affected

- RIGHTEST GS300 BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS550 Blood Glucose

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## Products Affected

- RIGHTEST GS550 BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rilutek

## Products Affected

- RILUTEK

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of amyotrophic lateral sclerosis (ALS) ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic equivalent alternative, riluzole
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented trial of one month of the preferred generic equivalent alternative, riluzole
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Riluzole

## Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of amyotrophic lateral sclerosis (ALS) ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic equivalent alternative, riluzole
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

# Risedronate Sodium

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## Products Affected

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

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



# Risedronate Sodium

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## Products Affected

- *risedronate sodium oral tablet 35 mg*

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

# Risedronate Sodium

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## Products Affected

- *risedronate sodium oral tablet 150 mg*

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

# RisperDAL

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## Products Affected

- RISPERDAL ORAL TABLET 4 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL

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## Products Affected

- RISPERDAL ORAL TABLET 1 MG, 0.5 MG, 3 MG, 0.25 MG, 2 MG

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

# RisperDAL

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## Products Affected

- RISPERDAL ORAL SOLUTION

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

# RisperDAL M-TAB

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## Products Affected

- RISPERDAL M-TAB ORAL TABLET  
DISPERSIBLE 3 MG, 0.5 MG, 1 MG, 2 MG

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

# RisperDAL M-TAB

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## Products Affected

- RISPERDAL M-TAB ORAL TABLET  
DISPERSIBLE 4 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperiDONE

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## Products Affected

- *risperidone oral tablet dispersible 3 mg, 0.25 mg, 1 mg, 0.5 mg, 2 mg*
- *risperidone oral tablet 0.25 mg, 2 mg, 0.5 mg, 1 mg, 3 mg*

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



# RisperiDONE

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## Products Affected

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

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

# RisperiDONE M-TAB

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## Products Affected

- RISPERIDONE M-TAB ORAL TABLET  
DISPERSIBLE 1 MG, 3 MG, 2 MG, 0.5 MG

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

# RisperiDONE M-TAB

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## Products Affected

- RISPERIDONE M-TAB ORAL TABLET  
DISPERSIBLE 4 MG

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

# 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 capsule Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# 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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

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## Products Affected

- RITALIN SR

<b>ST Criteria</b>	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr,Strattera, OR Vyvanse
<b>QL Criteria</b>	2 tabs Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Rizatriptan Benzoate

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## Products Affected

- *rizatriptan benzoate*

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

# Rizatriptan Benzoate

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## Products Affected

- *rizatriptan benzoate*

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

# ROPINIRole HCl ER

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## Products Affected

- *ropinirole hcl er oral tablet extended release*  
24 hr\* 4 mg, 2 mg, 6 mg, 8 mg

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

# ROPINIRole HCl ER

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## Products Affected

- *ropinirole hcl er oral tablet extended release*  
*24 hr\* 12 mg*

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

# Rozerem

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## Products Affected

- ROZEREM

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

# Sabril

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## Products Affected

- SABRIL ORAL TABLET

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

# Sanctura

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## Products Affected

- SANCTURA

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sancuso

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## Products Affected

- SANCUSO

<b>QL Criteria</b>	1 patch Per 21 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Saphris

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## Products Affected

- SAPHRIS

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

# Saphris

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## Products Affected

- SAPHRIS

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

# Savaysa

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## Products Affected

- SAVAYSA

<b>ST Criteria</b>	Trial of ONE month Eliquis AND Xarelto
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Savella

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## Products Affected

- SAVELLA

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

# Savella Titration Pack

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## Products Affected

- SAVELLA TITRATION PACK

<b>QL Criteria</b>	55 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Seasonique

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## Products Affected

- SEASONIQUE

<b>QL Criteria</b>	90 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ANDA 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 $\geq$ 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>QL Criteria</b>	4 caps Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Sentry Test

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## Products Affected

- *sentry test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Serevent Diskus

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## Products Affected

- SEREVENT DISKUS

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

# SEROquel

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## Products Affected

- SEROQUEL ORAL TABLET 300 MG, 400 MG

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

# SEROquel

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## Products Affected

- SEROQUEL ORAL TABLET 200 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

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## Products Affected

- SEROQUEL ORAL TABLET 25 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

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## Products Affected

- SEROQUEL ORAL TABLET 100 MG, 50 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	3 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel XR

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## Products Affected

- SEROQUEL XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 150 MG, 200  
MG

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

# SEROquel XR

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## Products Affected

- SEROQUEL XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 300 MG, 400  
MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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

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

# Sertraline HCl

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## Products Affected

- *sertraline hcl oral tablet 100 mg*

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

# Sertraline HCl

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## Products Affected

- *sertraline hcl oral tablet 50 mg*

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

# Sertraline HCl

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## Products Affected

- *sertraline hcl oral concentrate*

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

# Sertraline HCl

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## Products Affected

- *sertraline hcl oral tablet 25 mg*

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

# Shoprite Test

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## Products Affected

- *shoprite test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Shur-Seal Contraceptive

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## Products Affected

- SHUR-SEAL CONTRACEPTIVE

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

# Signifor

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## Products Affected

- SIGNIFOR

<b>QL Criteria</b>	10 Ampules Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Signifor LAR

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## Products Affected

- SIGNIFOR LAR

<b>QL Criteria</b>	1 injection Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sildenafil Citrate

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## Products Affected

- *sildenafil citrate oral*

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

# Silenor

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## Products Affected

- SILENOR

<b>ST Criteria</b>	Trial of 7 days (one week) each of generic doxepin AND zolpidem OR zolpidem er
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Simcor

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## Products Affected

- SIMCOR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 1000-40 MG, 500-40 MG

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

# Simcor

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## Products Affected

- SIMCOR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 500-20 MG, 750-20 MG,  
1000-20 MG

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

# Simponi

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## Products Affected

- SIMPONI

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

# Simvastatin

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## Products Affected

- *simvastatin oral*

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

# Singular

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## Products Affected

- SINGULAIR

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



# Singular

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**Products Affected**

- SINGULAIR

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

# Sirturo

## Products Affected

- SIRTURO

PA Criteria	Criteria Details
<b>Covered Uses</b>	pulmonary multi-drug resistant tuberculosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB) in adults AND all of the following: Member has failed or is failing an adequate treatment regimen* consisting of at least 4 drugs, administered under directly observed therapy (DOT) (or serum medication levels have been documented) or an adequate treatment regimen consisting of at least 4 drugs cannot otherwise be provided (Note: Treatment failure is defined as continuous or recurrently positive sputum cultures during the course of appropriate antituberculous therapy) Drug susceptibility testing for first and second-line agents will be performed and therapy will be initiated in combination with at least 3 other drugs which have shown susceptibility Treatment will be administered under directly observed therapy (DOT) An electrocardiogram (ECG) will be obtained before initiation of treatment, and at least 2, 12, and 24 weeks after starting treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 weeks
<b>Other Criteria</b>	According to the manufacturer, 400 mg of Sirturo should be taken daily for 2 weeks, then 200 mg of Sirturo should be taken three times weekly for 22 weeks. A quantity of this drug will be considered medically necessary as indicated in the table below if member fulfills above criteria:

<b>ST Criteria</b>	<p>A documented trial of at least three months of the preferred treatment regimen consisting of at least 2 of the following:</p> <ul style="list-style-type: none"> <li>ethambutol</li> <li>pyrazinamide</li> <li>Trecator (ethionamide)</li> <li>cycloserine</li> <li>Paser (aminosalicylic acid)</li> <li>amoxicillin/ clavulanate</li> <li>imipenem/ cilastatin</li> <li>clarithromycin</li> <li>Zyvox</li> </ul> <p>And 1 of the following:</p> <ul style="list-style-type: none"> <li>Avelox (moxifloxacin)</li> <li>levofloxacin</li> <li>ofloxacin</li> </ul> <p>And 1 of the following:</p> <ul style="list-style-type: none"> <li>amikacin</li> <li>capreomycin</li> <li>kanamycin</li> <li>streptomycin</li> </ul>
<b>QL Criteria</b>	68 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Sivextro

## Products Affected

- SIVEXTRO ORAL

PA Criteria	Criteria Details
Covered Uses	Infection of skin AND/OR subcutaneous tissue
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acute bacterial skin and skin structure infections (ABSSSI), and Culture and susceptibility information or, in the absence of such data, local epidemiology and susceptibility patterns indicate that the current infection is caused by one of the following Gram-positive microorganisms: Staph. aureus (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates), or Strep. pyogenes, or Strep. agalactiae, or Strep. anginosus Group (including Strep. anginosus, Strep. intermedius, and Strep. constellatus), or E. faecalis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
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

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## Products Affected

- SKELID

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

# Skyla

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## Products Affected

- SKYLA

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

# Smart Diabetes Xpres Test

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## Products Affected

- SMART DIABETES XPRES TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Smart Sense Premium Test

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## Products Affected

- SMART SENSE PREMIUM TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Smart Sense Value Test

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## Products Affected

- SMART SENSE VALUE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Smartest Blood Glucose Test

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## Products Affected

- SMARTEST BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Solia

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## Products Affected

- SOLIA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For ALL tetracyclines(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)(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)
Age Restrictions	less 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

# Solus V2 Test

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## Products Affected

- SOLUS V2 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sonata

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## Products Affected

- SONATA ORAL CAPSULE 5 MG

<b>ST Criteria</b>	Trial of 7 days (one week) of the preferred generic alternative zolpidem OR zolpidem er.
<b>QL Criteria</b>	4 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sonata

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## Products Affected

- SONATA ORAL CAPSULE 10 MG

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

# Soolantra

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## Products Affected

- SOOLANTRA

<b>ST Criteria</b>	Trial of one month each of topical metronidazole AND sulfacetamide sodium with sulfur
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sorilux

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## Products Affected

- SORILUX

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

# Spiriva HandiHaler

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## Products Affected

- SPIRIVA HANDIHALER

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

# Spiriva Respimat

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## Products Affected

- SPIRIVA RESPIMAT INHALATION  
AEROSOL, SOLUTION 1.25 MCG/ACT

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

# Spiriva Respimat

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## Products Affected

- SPIRIVA RESPIMAT INHALATION  
AEROSOL, SOLUTION 2.5 MCG/ACT

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

# Sporanox

## Products Affected

- SPORANOX

PA Criteria	Criteria Details
<b>Covered Uses</b>	Aspergillosis, Invasive, salvage therapy Blastomycosis Candidiasis of the esophagus Histoplasmosis, Disseminated Onychomycosis due to dermatophyte Oropharyngeal candidiasis Pulmonary histoplasmosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)AspergillosisBlastomycosisTreatment of oropharyngeal/esophageal candidiasis in HIV-infected personsChromoblastomycosisCoccidioidomycosis associated with AIDS, treatment and prophylaxisCryptococcosisCryptococcal meningitis - HIV infectionCutaneous 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] ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of one topical antifungal AND preferred generic oral terbinafineFebrile neutropeniaHistoplasmosisPenicillium marneffeii infectionProphylaxis of invasive fungal infections in persons with Chronic Granulomatous Disease, hematologic malignancies or liver transplantsDisseminated microsporidiosis caused by Trachipleistophora or Brachiola species in HIV-infected personsOnychomycosis (Tinea unguium) due to dermatophyte ANDA 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)ANDA 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 diseaseFungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection)ParacoccidioidomycosisSporotrichosisTinea versicolorTinea capitis AND A documented contraindication/intolerance/allergy/failure of two weeks of generic terbinafineVulvovaginal Candidiasis
<b>Age Restrictions</b>	

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

# Sporanox Pulsepak

## Products Affected

- SPORANOX PULSEPAK

PA Criteria	Criteria Details
<b>Covered Uses</b>	Aspergillosis, Invasive, salvage therapy Blastomycosis Candidiasis of the esophagus Histoplasmosis, Disseminated Onychomycosis due to dermatophyte Oropharyngeal candidiasis Pulmonary histoplasmosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)AspergillosisBlastomycosisTreatment of oropharyngeal/esophageal candidiasis in HIV-infected personsChromoblastomycosisCoccidioidomycosis associated with AIDS, treatment and prophylaxisCryptococcosisCryptococcal meningitis - HIV infectionCutaneous 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] ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of one topical antifungal AND preferred generic oral terbinafineFebrile neutropeniaHistoplasmosisPenicillium marneffeii infectionProphylaxis of invasive fungal infections in persons with Chronic Granulomatous Disease, hematologic malignancies or liver transplantsDisseminated microsporidiosis caused by Trachipleistophora or Brachiola species in HIV-infected personsOnychomycosis (Tinea unguium) due to dermatophyte ANDA 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 diseaseFungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection)ParacoccidioidomycosisSporotrichosisTinea versicolorTinea capitis AND A documented contraindication/intolerance/allergy/failure of two weeks of generic terbinafineVulvovaginal Candidiasis
<b>Age Restrictions</b>	

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



# Sprintec 28

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## Products Affected

- SPRINTEC 28

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

# Sprix

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## Products Affected

- SPRIX

<b>QL Criteria</b>	5 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sprycel

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## Products Affected

- SPRYCEL

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

# Sronyx

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## Products Affected

- SRONYX

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

# Stimate

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## 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	
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

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## Products Affected

- STIOLTO RESPIMAT

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

# Strattera

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## Products Affected

- STRATTERA ORAL CAPSULE 25 MG, 10 MG, 18 MG, 40 MG, 60 MG

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

# Strattera

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## Products Affected

- STRATTERA ORAL CAPSULE 100 MG, 80 MG

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



# Striant

## Products Affected

- STRIANT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	2 buccals Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Stribild

## Products Affected

- STRIBILD

PA Criteria	Criteria Details
<b>Covered Uses</b>	human immunodeficiency virus (HIV)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of human immunodeficiency virus (HIV)A documented resistance test within the past 3 months demonstrating virologic susceptibility to all of the following components of Stribild: elvitegravir, emtricitabine, and tenofovir AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Atripla (efavirenz-emtricitabine-tenofovir) or a documented resistance test within the past 3 months demonstrating virologic resistance to efavirenz ORA documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Truvada, Reyataz, and Norvir (emtricitabine-tenofovir, atazanavir, ritonavir) in combination or documented resistance test within the past 3 months demonstrating virological resistance to atazanavir ORA documented viral load assay AND CD4 count indicating that the patient is stable on Stribild (stable or increase in CD4 counts AND viral load less than 50 copies/ml) (FOR renewals ONLY)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Striverdi Respimat

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## Products Affected

- STRIVERDI RESPIMAT

PA Criteria	Criteria Details
Covered Uses	Chronic Ostructive 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 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Suboxone

## Products Affected

- SUBOXONE SUBLINGUAL FILM 8-2 MG, 2-0.5 MG, 4-1 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>QL Criteria</b>	90 pack Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Suboxone

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## Products Affected

- SUBOXONE SUBLINGUAL TABLET  
SUBLINGUAL

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

# Suboxone

## Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>QL Criteria</b>	2 pack Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Subsys

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## Products Affected

- SUBSYS SUBLINGUAL LIQUID† 1600 (800 X 2) MCG, 1200 (600 X 2) MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer pain, General anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation 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</p>
<b>ST Criteria</b>	Trial of one week of generic fentanyl transmucosal lozenge
<b>QL Criteria</b>	8 pack Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Subsys

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## Products Affected

- SUBSYS SUBLINGUAL LIQUID† 600 MCG, 800 MCG, 400 MCG, 200 MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer pain, General anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation 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</p>
<b>ST Criteria</b>	Trial of one week of generic fentanyl transmucosal lozenge
<b>QL Criteria</b>	15 pack Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Subsys

## Products Affected

- SUBSYS SUBLINGUAL LIQUID† 100 MCG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Breakthrough cancer pain, General anesthesia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (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)AND Documentation 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</p>

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

<b>ST Criteria</b>	Trial of one week of generic fentanyl transmucosal lozenge
<b>QL Criteria</b>	15 ml Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Subutex

## Products Affected

- SUBUTEX

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>ST Criteria</b>	Trial of ONE month of buprenorphine SL
<b>QL Criteria</b>	90 tablets Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sulfacetamide Sodium

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## Products Affected

- *sulfacetamide sodium ophthalmic solution*

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

# SulfaSALazine

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## Products Affected

- *sulfasalazine oral*

<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sulfazine

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**Products Affected**

- SULFAZINE

<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sulfazine EC

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## Products Affected

- SULFAZINE EC

<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SUMAtriptan Succinate

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## Products Affected

- *sumatriptan succinate oral*

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

# Sumavel DosePro

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## Products Affected

- SUMAVEL DOSEPRO

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

# Supreme Test

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## Products Affected

- SUPREME TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sure Edge Test

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## Products Affected

- SURE EDGE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# SureChek Blood Glucose Test

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## Products Affected

- SURECHEK BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SureStep Pro Test

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## Products Affected

- SURESTEP PRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SureStep Test

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## Products Affected

- SURESTEP TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sure-Test EasyPlus Mini Test

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## Products Affected

- SURE-TEST EASYPLUS MINI TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sutent

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## Products Affected

- SUTENT ORAL CAPSULE 50 MG, 25 MG, 12.5 MG

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

# Syeda

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## Products Affected

- SYEDA

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

# Symbicort

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## Products Affected

- SYMBICORT

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

# Symbyax

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## Products Affected

- SYMBYAX

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



# SymLinPen 120

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## 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

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## Products Affected

- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Diabetes
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Synjardy

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## Products Affected

- SYNJARDY

<b>ST Criteria</b>	Trial of 1 month of Invokana (single entity or combination)
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tacrolimus

## Products Affected

- *tacrolimus external*

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	?16 FOR 0.1%
Prescriber Restrictions	
Coverage Duration	Face, genital area: 3 months, Other body areas: 6 months, Patients less than 2 yrs : 3 months
Other Criteria	
QL Criteria	60 GM Per 1 fill
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

# Tafinlar

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## Products Affected

- TAFINLAR

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

# Tamiflu

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## Products Affected

- TAMIFLU ORAL CAPSULE 30 MG, 45 MG

<b>QL Criteria</b>	20 caps Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tamiflu

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## Products Affected

- TAMIFLU ORAL SUSPENSION  
RECONSTITUTED 6 MG/ML

<b>QL Criteria</b>	480 pen Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tamiflu

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## Products Affected

- TAMIFLU ORAL CAPSULE 75 MG

<b>QL Criteria</b>	2 pack Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tanzeum

## Products Affected

- TANZEUM

PA Criteria	Criteria Details
Covered Uses	Type II diabetes
Exclusion Criteria	no personal or family history of medullary thyroid carcinoma (MTC),OR, Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month Each of Bydureon AND Victoza
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

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## Products Affected

- TARCEVA

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

# TargaDOX

## Products Affected

- TARGADOX

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(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)  (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)
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Tasigna

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## Products Affected

- TASIGNA

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

# Tazorac

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## Products Affected

- TAZORAC

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

# Technivie

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## Products Affected

- TECHNIVIE

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

# Tekamlo

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## Products Affected

- TEKAMLO

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



# Tekturna

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## Products Affected

- TEKTURNA

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

# Tekturna HCT

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## Products Affected

- TEKTURNA HCT ORAL TABLET 150-25 MG, 150-12.5 MG

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

# Telcare Blood Glucose Test

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## Products Affected

- TELCARE BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Temodar

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## Products Affected

- TEMODAR ORAL

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

# Temozolomide

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## Products Affected

- *temozolomide*

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Cutaneous leishmaniasis Cutaneous sporotrichosis Paracoccidioidomycosis Seborrheic dermatitis Tinea capitis Onychomycosis (Tinea unguium)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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] ANDA 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 ANDA 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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

# Testim

## Products Affected

- TESTIM

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	10 GM Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Testosterone

## Products Affected

- testosterone transdermal 25 mg/2.5gm (1%)

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 packets Per 1 month
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>



# Testosterone

## Products Affected

- *testosterone transdermal 50 mg/5gm (1%)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	60 packets Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Testosterone

## Products Affected

- *testosterone transdermal 12.5 mg/act (1%)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Testosterone

## Products Affected

- *testosterone transdermal 10 mg/act (2%)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 pumps Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Tetrabenazine

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## Products Affected

- *tetrabenazine oral tablet 25 mg*

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

# Tetrabenazine

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## Products Affected

- *tetrabenazine oral tablet 12.5 mg*

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	A documented diagnosis of hypertension, ANDA 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	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
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	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred alternatives from the following: candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TGT Blood Glucose Test

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## Products Affected

- *tgt blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# TiaGABine HCl

---

## Products Affected

- *tia gabine hcl oral tablet 4 mg*

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

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

# Tilia Fe

---

## Products Affected

- TILIA FE

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

# Tivorbex

---

## Products Affected

- TIVORBEX

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

# TobraDex

---

## Products Affected

- TOBRADEX OPHTHALMIC SUSPENSION

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

# TobraDex ST

---

## Products Affected

- TOBRADEX ST

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

# Tobramycin

---

## Products Affected

- *tobramycin ophthalmic*

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

# Tobramycin-Dexamethasone

---

## Products Affected

- *tobramycin-dexamethasone*

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



# Tobrex

---

## Products Affected

- TOBREX OPHTHALMIC SOLUTION

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

# Today Sponge

---

## Products Affected

- TODAY SPONGE

<b>QL Criteria</b>	10 devices Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Topamax Sprinkle

---

## Products Affected

- TOPAMAX SPRINKLE

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

# Topiramate

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## Products Affected

- *topiramate oral capsule sprinkle*

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

# Toviaz

---

## Products Affected

- TOVIAZ

<b>ST Criteria</b>	Trial of one month of either tropsium/tropsium er or tolteridine/tolteridine er AND one month of Enablex, Myrbetriq, or Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tradjenta

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## Products Affected

- TRADJENTA

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

# TraMADol HCl ER

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## Products Affected

- *tramadol hcl er oral capsule extended release*  
24 hour 300 mg, 100 mg, 200 mg

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

# Tranexamic Acid

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## Products Affected

- *tranexamic acid oral*

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



# Travatan Z

---

## Products Affected

- TRAVATAN Z

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

# Travoprost

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## Products Affected

- *travoprost*

<b>QL Criteria</b>	3 ML Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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 tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple 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*

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	greater than 35
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	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 tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple 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 tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple 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 each of two preferred alternatives indicated for the members 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

# Treximet

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## Products Affected

- TREXIMET

<b>ST Criteria</b>	Trial of one month of 3 of the following: naratriptan, rizatriptan, sumatriptan, or zolmitriptan, AND concurrent use of prescription strength naproxen $\geq$ 500mg
<b>QL Criteria</b>	9 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Trezix

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## Products Affected

- TREZIX ORAL CAPSULE 320.5-30-16 MG

<b>QL Criteria</b>	10 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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, ANDA 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 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
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

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## Products Affected

- TRICOR

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

# Tri-Estarylla

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## Products Affected

- TRI-ESTARYLLA

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

# Trifluridine

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## Products Affected

- *trifluridine ophthalmic*

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

# Triglide

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## Products Affected

- TRIGLIDE ORAL TABLET 160 MG

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

# Tri-Legest Fe

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## Products Affected

- TRI-LEGEST FE

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

# Tri-Linyah

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## Products Affected

- TRI-LINYAH

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



# Trilipix

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## Products Affected

- TRILIPIX

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

# TriNessa (28)

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## Products Affected

- TRINESSA (28)

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

# Tri-Previfem

---

## Products Affected

- TRI-PREVIFEM

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

# Tri-Sprintec

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## Products Affected

- TRI-SPRINTEC

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

# Trivora (28)

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## Products Affected

- TRIVORA (28)

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

# Trokendi XR

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## Products Affected

- TROKENDI XR ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 25 MG, 50  
MG, 100 MG

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

# Trokendi XR

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## Products Affected

- TROKENDI XR ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 200 MG

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

# Trospium Chloride

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## Products Affected

- *trospium chloride*

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Trospium Chloride ER

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## Products Affected

- *trospium chloride er*

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# True Care Test Strip Pack

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## Products Affected

- *true care test strip pack*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TRUEtest Test

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## Products Affected

- TRUETEST TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TrueTrack Test

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## Products Affected

- TRUETRACK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Trulicity

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## Products Affected

- TRULICITY

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

# Truvada

## Products Affected

- TRUVADA

PA Criteria	Criteria Details
<b>Covered Uses</b>	human immunodeficiency virus (HIV)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of human immunodeficiency virus (HIV) OR A documented diagnosis of initiating therapy for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk AND documentation of all of the following: A negative HIV antibody test taken: Immediately before starting Truvada for PrEP AND Every 3 months thereafter while on therapy Confirmation that creatinine clearance value greater than $\geq 60$ mL/min before initiating Truvada for PrEP AND Serum creatinine and calculate creatinine clearance checks performed at 3 months after initiation and then every 6 months thereafter NOTE: Members may receive a 30 days' supply of medication upon initial request of Truvada for PrEP diagnosis. After 30 days, above criteria must be met.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	PrEP- 3 months (renewals approved pending HIV testing and CrCl value), HIV-1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tudorza Pressair

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## Products Affected

- TUDORZA PRESSAIR

PA Criteria	Criteria Details
Covered Uses	Chronic Ostructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
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

# Twinject

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## Products Affected

- TWINJECT INJECTION 0.15 MG/0.15ML

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



# Tybost

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## Products Affected

- TYBOST

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

# Tykerb

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## Products Affected

- TYKERB

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

# Uceris

## Products Affected

- UCERIS ORAL

PA Criteria	Criteria Details
Covered Uses	ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of active, mild to moderate ulcerative colitis and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of two preferred 5-ASA therapies (i.e., balsalazide, Canasa, Delzicol) and one preferred generic corticosteroid therapy (i.e., budesonide sr, prednisone, prednisolone)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uceris

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## Products Affected

- UCERIS

<b>ST Criteria</b>	Trial of Asacol HD, Delzicol, Lialda OR Pentasa
<b>QL Criteria</b>	4 canisters Per 42 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uloric

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## Products Affected

- ULORIC

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

# Ultima Test

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## Products Affected

- ULTIMA TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# UltraTRAK PRO Test

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## Products Affected

- ULTRATRAK PRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# UltraTRAK Ultimate Test

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## Products Affected

- ULTRATRAK ULTIMATE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Ultresa

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## Products Affected

- ULTRESA

<b>ST Criteria</b>	Trial of two weeks of two preferred alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Unistrip1 Generic

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## Products Affected

- UNISTRIP1 GENERIC

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valcyte

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## Products Affected

- VALCYTE ORAL SOLUTION  
RECONSTITUTED

<b>QL Criteria</b>	1000 ml Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valcyte

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## Products Affected

- VALCYTE ORAL TABLET

<b>QL Criteria</b>	102 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ValGANciclovir HCl

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## Products Affected

- *valganciclovir hcl*

<b>QL Criteria</b>	102 tablets Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valsartan-Hydrochlorothiazide

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## Products Affected

- *valsartan-hydrochlorothiazide oral tablet*  
*160-25 mg, 160-12.5 mg, 80-12.5 mg*

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

# Valtrex

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## Products Affected

- VALTRESX

<b>ST Criteria</b>	Trial of one week of generic valacyclovir
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vascepa

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## Products Affected

- VASCEPA

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



# VCF Vaginal Contraceptive

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## Products Affected

- VCF VAGINAL CONTRACEPTIVE VAGINAL FOAM
- VCF VAGINAL CONTRACEPTIVE VAGINAL FILM

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

# Vecamyl

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## Products Affected

- VECAMYL

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

# Velivet

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## Products Affected

- VELIVET

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

# Venlafaxine HCl

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## Products Affected

- *venlafaxine hcl oral tablet 25 mg, 100 mg*

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

# Venlafaxine HCl

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## Products Affected

- *venlafaxine hcl oral tablet 75 mg*

<b>QL Criteria</b>	5 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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\* 225 mg

<b>ST Criteria</b>	Trial of venlafaxine (NSO)
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl ER

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## Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

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

# Ventolin HFA

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## Products Affected

- VENTOLIN HFA

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

# Verdeso

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## Products Affected

- VERDESO

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

# Versacloz

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## Products Affected

- VERSACLOZ

<b>ST Criteria</b>	Trial of clozapine
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vestura

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## Products Affected

- VESTURA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For ALL tetracyclines(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)(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)
Age Restrictions	less 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

# Victory AGM-4000 Test

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## Products Affected

- VICTORY AGM-4000 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Victoza

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## Products Affected

- VICTOZA

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

# Victrelis

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## Products Affected

- VICTRELIS

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

# Vigamox

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## Products Affected

- VIGAMOX

<b>QL Criteria</b>	5 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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

## 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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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 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.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
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

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## Products Affected

- VIMOVO

<b>ST Criteria</b>	Trial of two weeks of one preferred generic nonsteroidal anti-inflammatory agent
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vimpat

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## Products Affected

- VIMPAT ORAL TABLET 200 MG, 150 MG, 100 MG

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



# Vimpat

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## Products Affected

- VIMPAT ORAL SOLUTION

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

# Vimpat

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## Products Affected

- VIMPAT ORAL TABLET 50 MG

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

# Viokace

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## Products Affected

- VIOKACE

<b>ST Criteria</b>	Trial of two weeks of two preferred alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viorele

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## Products Affected

- *viorele*

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

# Viramune

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## Products Affected

- VIRAMUNE

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

# Viroptic

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## Products Affected

- VIROPTIC

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

# Vivelle-Dot

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## Products Affected

- VIVELLE-DOT

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

# Vocal Point Blood Glucose Test

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## Products Affected

- VOCAL POINT BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vogelxo

## Products Affected

- VOGELXO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	60 packets Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Vogelxo Pump

## Products Affected

- VOGELXO PUMP

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	4 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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

# Voltaren

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## Products Affected

- VOLTAREN TRANSDERMAL

<b>QL Criteria</b>	5 tubes Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Votrient

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## Products Affected

- VOTRIENT

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

# Vyfemla

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## Products Affected

- VYFEMLA

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

# Vytorin

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## Products Affected

- VYTORIN

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

# Vyvanse

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## Products Affected

- VYVANSE

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

# Vyvanse

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## Products Affected

- VYVANSE

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



# WaveSense Presto

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## Products Affected

- WAVESENSE PRESTO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wellbutrin

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## Products Affected

- WELLBUTRIN

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

# Wellbutrin SR

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## Products Affected

- WELLBUTRIN SR

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

# Wellbutrin XL

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## Products Affected

- WELLBUTRIN XL

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

# Wera

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## Products Affected

- WERA

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

# Wide-Seal Diaphragm 60

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## Products Affected

- WIDE-SEAL DIAPHRAGM 60

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

# Wide-Seal Diaphragm 65

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## Products Affected

- WIDE-SEAL DIAPHRAGM 65

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

# Wide-Seal Diaphragm 70

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## Products Affected

- WIDE-SEAL DIAPHRAGM 70

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



# Wide-Seal Diaphragm 75

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## Products Affected

- WIDE-SEAL DIAPHRAGM 75

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

# Wide-Seal Diaphragm 80

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## Products Affected

- WIDE-SEAL DIAPHRAGM 80

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

# Wide-Seal Diaphragm 85

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## Products Affected

- WIDE-SEAL DIAPHRAGM 85

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

# Wide-Seal Diaphragm 90

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## Products Affected

- WIDE-SEAL DIAPHRAGM 90

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

# Wide-Seal Diaphragm 95

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## Products Affected

- WIDE-SEAL DIAPHRAGM 95

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

# Winn Dixie Medic Test

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## Products Affected

- *winn dixie medic test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wymzya Fe

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## Products Affected

- WYMZYA FE

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

# Xalatan

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## Products Affected

- XALATAN

<b>ST Criteria</b>	Trial of 1 week of latanoprost AND Travatan Z
<b>QL Criteria</b>	3 ML Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Xalkori

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## Products Affected

- XALKORI

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

# Xanax XR

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## Products Affected

- XANAX XR

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

# Xarelto

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## Products Affected

- XARELTO ORAL TABLET 10 MG

<b>QL Criteria</b>	35 tab Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xarelto

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## Products Affected

- XARELTO ORAL TABLET 15 MG

<b>QL Criteria</b>	42 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xarelto

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## Products Affected

- XARELTO ORAL TABLET 20 MG

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

# Xarelto Starter Pack

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## Products Affected

- XARELTO STARTER PACK

<b>QL Criteria</b>	2 packs Per 325 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xartemis XR

## Products Affected

- XARTEMIS XR

PA Criteria	Criteria Details
Covered Uses	acute pain
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acute pain severe enough to require opioid treatment and for which alternative treatment options are inadequate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, member's treating physician must request prior authorization through the Aetna Pharmacy Management Precertification Unit. Additional quantities of the above medications will be considered medically necessary for those members who meet the following criterion: (1) A documented diagnosis of cancer and prescription is written by an oncologist or pain specialist, or (2) Member is enrolled in a hospice program or meets hospice criteria, or (3) Member's resident state or contract state is California and the member is terminally ill, or (4) 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 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. Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. Exceptions to requiring the signed opioid agreement for additional quantities are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)
ST Criteria	Trial of two days each of two preferred generic short-acting opioid alternatives, i.e., morphine, hydrocodone, oxycodone, hydromorphone
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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

# Xeljanz

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## Products Affected

- XELJANZ

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



# Xeloda

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## Products Affected

- XELODA

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

# Xenazine

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## Products Affected

- XENAZINE ORAL TABLET 12.5 MG

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

# Xenazine

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## Products Affected

- XENAZINE ORAL TABLET 25 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR hepatic encephalopathy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever)ORA documented diagnosis of hepatic encephalopathyANDA documented:Contraindication to one preferred alternative agent indicated for the member's condition ORIntolerance to one preferred alternative agent indicated for the member's condition ORAllergy to one preferred alternative agent indicated for the member's condition ORFailure of an adequate trial of two weeks of one preferred alternative agent indicated for the member's condition
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Hepatic encephalopathy: One year Traveler's Diarrhea: 1 Week
<b>Other Criteria</b>	
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR hepatic encephalopathy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever)ORA documented diagnosis of hepatic encephalopathyANDA documented:Contraindication to one preferred alternative agent indicated for the member's condition ORIntolerance to one preferred alternative agent indicated for the member's condition ORAllergy to one preferred alternative agent indicated for the member's condition ORFailure of an adequate trial of two weeks of one preferred alternative agent indicated for the member's condition
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Hepatic encephalopathy: One year Traveler's Diarrhea: 1 Week
<b>Other Criteria</b>	
<b>QL Criteria</b>	9 tab Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xigduo XR

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## Products Affected

- XIGDUO XR

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

# Xopenex HFA

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## Products Affected

- XOPENEX HFA

<b>ST Criteria</b>	Trial of 1 week each of Ventolin HFA AND Proair
<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xtandi

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## Products Affected

- XTANDI

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



# Xulane

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## Products Affected

- XULANE

<b>QL Criteria</b>	3 patches Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	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	Member and physician are enrolled in the Xyrem Success Program, and (1) Member has a documented diagnosis of narcolepsy confirmed by sleep lab evaluation, or (2) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	18 ml Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xyzal

## Products Affected

- XYZAL ORAL SOLUTION

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ANDA 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 $\geq$ 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>QL Criteria</b>	10 ml Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Xyzal

## Products Affected

- XYZAL ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 ANDA 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
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# Zaleplon

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## Products Affected

- *zaleplon oral capsule 10 mg*

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

# Zaleplon

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## Products Affected

- *zaleplon oral capsule 5 mg*

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



# Zarah

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## Products Affected

- ZARAH

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

# Zecuity

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## Products Affected

- ZECUITY

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

# Zegerid

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## Products Affected

- ZEGERID ORAL CAPSULE 40-1100 MG

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

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

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zegerid

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## Products Affected

- ZEGERID ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(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 (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), 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 above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>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: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) 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) and (b) Member is experiencing acid breakthrough, OR (c) 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.</p>

<b>ST Criteria</b>	(1) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of lansoprazole, an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate), AND pantoprazole, AND (2) A documented contraindication or intolerance or allergy or failure of an adequate trial of one month Dexilant AND Nexium, OR (3) 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.
<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zelapar

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## Products Affected

- ZELAPAR

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

# Zelboraf

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## Products Affected

- ZELBORAF

<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	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 recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenchant

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## Products Affected

- ZENCHENT

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

# Zenchant FE

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## Products Affected

- ZENCHENT FE

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

# Zenzedi

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## Products Affected

- ZENZEDI

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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	
ST Criteria	Trial of 14 days EACH of 3 of the following: amphetamine/dextroamphetamine/sr, dexamethylphenidate/ 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

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## Products Affected

- ZEOSA

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



# Zerit

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## Products Affected

- ZERIT

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

# Zetia

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## Products Affected

- ZETIA

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

# Zetonna

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## Products Affected

- ZETONNA

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

# Ziagen

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## Products Affected

- ZIAGEN

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

# Zioptan

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## Products Affected

- ZIOPTAN

<b>ST Criteria</b>	Trial of 1 week of latanoprost AND Travatan Z
<b>QL Criteria</b>	1 unit Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ziprasidone HCl

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## Products Affected

- *ziprasidone hcl*

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

# Zocor

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## Products Affected

- ZOCOR

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

# Zofran

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## Products Affected

- ZOFRAN ORAL SOLUTION

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



# Zofran

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## Products Affected

- ZOFRAN ORAL TABLET

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

# Zofran ODT

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## Products Affected

- ZOFRAN ODT

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

# Zohydro ER

## Products Affected

- ZOHYDRO ER ORAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented progression through the World Health Organization analgesic ladder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR</p> <p>Member is enrolled in a hospice program or meets hospice criteria OR</p> <p>Member's resident state or contract state is California and the member is terminally ill OR</p> <p>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)</p> <p>Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.</p> <p>*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)</p> <p>AND</p> <p>Documentation of one of the following:A documented diagnosis of moderate to severe chronic pain</p> <p>AND</p> <p>formal pain evaluation has been documented</p> <p>AND</p> <p>Other pain management regimens have been inadequate</p>

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zohydro ER

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## Products Affected

- ZOHYDRO ER ORAL CAPSULE  
EXTENDED RELEASE 12 HOUR

<b>ST Criteria</b>	Trial of ONE month each of the following preferred generic alternatives: morphine sr cap 24hr (Kadian CR) OR morphine sr tab 12hr (MS Contin), AND oxymorphone er (Opana ER)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoledronic Acid

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## Products Affected

- *zoledronic acid intravenous\* concentrate*

<b>QL Criteria</b>	1 vial Per 21 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoledronic Acid

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## Products Affected

- *zoledronic acid intravenous\* solution 5 mg/100ml*

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

# Zolinza

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## Products Affected

- ZOLINZA

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



# ZOLMitriptan

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## Products Affected

- *zolmitriptan oral tablet 5 mg*
- *zolmitriptan oral tablet dispersible 5 mg*

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

# ZOLMitriptan

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## Products Affected

- *zolmitriptan oral tablet dispersible 2.5 mg*
- *zolmitriptan oral tablet 2.5 mg*

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

# Zoloft

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## Products Affected

- ZOLOFT ORAL TABLET 25 MG

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

# Zoloft

---

## Products Affected

- ZOLOFT ORAL TABLET 100 MG

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

# Zoloft

---

## Products Affected

- ZOLOFT ORAL CONCENTRATE

<b>QL Criteria</b>	10 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoloft

---

## Products Affected

- ZOLOFT ORAL TABLET 50 MG

<b>QL Criteria</b>	45 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	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*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zolpidem Tartrate ER

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## Products Affected

- *zolpidem tartrate er*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolpimist

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## Products Affected

- ZOLPIMIST

<b>ST Criteria</b>	Trial of 7 days (one week) of the preferred generic alternative zolpidem OR zolpidem er.
<b>QL Criteria</b>	1 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zometa

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## Products Affected

- ZOMETA INTRAVENOUS\* SOLUTION

<b>QL Criteria</b>	1 vial Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zometa

---

## Products Affected

- ZOMETA INTRAVENOUS\*  
CONCENTRATE

<b>QL Criteria</b>	1 vial Per 21 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

---

## Products Affected

- ZOMIG NASAL SOLUTION 2.5 MG

<b>QL Criteria</b>	6 ml Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

---

## Products Affected

- ZOMIG NASAL SOLUTION 5 MG

<b>QL Criteria</b>	1 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

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## Products Affected

- ZOMIG ORAL

<b>QL Criteria</b>	6 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig ZMT

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## Products Affected

- ZOMIG ZMT

<b>QL Criteria</b>	6 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zorvolex

---

## Products Affected

- ZORVOLEX

<b>QL Criteria</b>	3 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Zovia 1/35E (28)

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### Products Affected

- ZOVIA 1/35E (28)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Zovia 1/50E (28)

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### Products Affected

- ZOVIA 1/50E (28)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 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
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>ST Criteria</b>	Trial of ONE month of buprenorphine-naloxone sublingual tablet
<b>QL Criteria</b>	90 tab Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 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
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	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
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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 <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. 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).</p>
<b>ST Criteria</b>	Trial of ONE month of buprenorphine-naloxone sublingual tablet
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zuplenz

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## Products Affected

- ZUPLENZ

<b>QL Criteria</b>	12 pack Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyban

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## Products Affected

- ZYBAN

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyclara

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## Products Affected

- ZYCLARA

<b>QL Criteria</b>	56 EA Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyclara Pump

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## Products Affected

- ZYCLARA PUMP EXTERNAL CREAM 3.75  
%

<b>QL Criteria</b>	56 packets Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyclara Pump

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## Products Affected

- ZYCLARA PUMP EXTERNAL CREAM 2.5  
%

<b>QL Criteria</b>	2 bottle Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zylet

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## Products Affected

- ZYLET

<b>QL Criteria</b>	1 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zymaxid

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## Products Affected

- ZYMAXID

<b>QL Criteria</b>	6 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA

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## Products Affected

- ZYPREXA ORAL TABLET 10 MG, 5 MG, 15 MG, 7.5 MG, 20 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA

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## Products Affected

- ZYPREXA ORAL TABLET 2.5 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA Zydis

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## Products Affected

- ZYPREXA ZYDIS

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zytiga

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## Products Affected

- ZYTIGA

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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LEENA .....	689	LOTREL .....	736
<i>leflunomide oral</i> .....	690	LOTRONEX .....	737
LEMTRADA .....	691	<i>lovastatin</i> .....	738
LENVIMA 10 MG DAILY DOSE .....	692	LOVAZA .....	739
LENVIMA 14 MG DAILY DOSE .....	693	LOW-OGESTREL .....	740
LENVIMA 20 MG DAILY DOSE .....	694		

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LUMIGAN OPHTHALMIC SOLUTION 0.01 %	741	<i>methylphenidate hcl oral tablet chewable</i>	776
.....	741	MEVACOR	784
LUNESTA	742	MIACALCIN NASAL	785
LUTERA	743	MICRODOT TEST	786
LUVOX CR	744	MICROGESTIN 1.5/30	787
LUXIQ	745	MICROGESTIN 1/20	788
LYNPARZA	746	MICROGESTIN FE 1.5/30	789
LYSTEDA	747	MICROGESTIN FE 1/20	790
LYZA	748	MIGRANAL	791
MAKENA	749	MIMVEY	792
MALARONE	750	MINIVELLE	793
MARINOL	751	MINOCIN ORAL CAPSULE 100 MG, 50 MG	794
<i>marlissa</i>	752	.....	794
MAXALT	753	<i>minocycline hcl er</i>	796
MAXALT-MLT	754	MIRAPEX ER	797
MAXIMA BLOOD GLUCOSE TEST	755	MIRENA	798
MAXITROL OPHTHALMIC SUSPENSION	756	<i>mirtazapine oral tablet 30 mg, 15 mg, 45 mg</i>	799
<i>medroxyprogesterone acetate intramuscular*</i>	757	<i>mirtazapine oral tablet dispersible</i>	799
<i>mefloquine hcl</i>	758	MIRVASO	800
<i>meijer blood glucose test</i>	759	MITIGARE	801
<i>meijer premium glucose test</i>	760	<i>modafinil</i>	802
<i>meijer test</i>	761	MONODOX ORAL CAPSULE 100 MG, 75 MG	803
MEIJER TRUETEST TEST	762	.....	803
MEIJER TRUETRACK TEST	763	MONO-LINYAH	805
MEKINIST	764	MONONESSA	806
MENOSTAR	765	<i>montelukast sodium oral</i>	807
METADATE CD	766	<i>montelukast sodium oral</i>	808
METADATE ER	767	MOVANTIK	809
<i>methadone hcl oral tablet</i>	768	MOXEZA	810
<i>methadone hcl oral tablet soluble</i>	768	MS CONTIN	811
METHADOSE ORAL TABLET	769	MYGLUCOHEALTH TEST	812
METHADOSE ORAL TABLET SOLUBLE	769	MYORISAN ORAL CAPSULE 10 MG, 20 MG,	813
<i>methamphetamine hcl</i>	770	40 MG	813
METHYLIN ORAL SOLUTION 10 MG/5ML	772	MYZILRA	814
.....	772	<i>naratriptan hcl</i>	815
METHYLIN ORAL SOLUTION 5 MG/5ML	773	NATACYN	816
METHYLIN ORAL TABLET CHEWABLE	771	NATESTO	817
<i>methylphenidate hcl er (cd)</i>	781	NATPARA	818
<i>methylphenidate hcl er (la) oral capsule extended</i>	783	NAVARRO BLOOD GLUCOSE TEST	819
<i>release 24 hour 20 mg, 40 mg</i>	783	NECON 0.5/35 (28)	820
<i>methylphenidate hcl er (la) oral capsule extended</i>	782	NECON 1/35 (28)	821
<i>release 24 hour 30 mg</i>	782	NECON 10/11 (28)	822
<i>methylphenidate hcl er oral tablet</i>	780	NECON 7/7/7	823
<i>extendedrelease* 20 mg</i>	780	<i>nefazodone hcl oral tablet 250 mg, 50 mg</i>	824
<i>methylphenidate hcl er oral tablet</i>	779	<i>neomycin-polymyxin-dexameth ophthalmic</i>	825
<i>extendedrelease* 27 mg, 54 mg, 18 mg</i>	779	<i>suspension 3.5-10000-0.1</i>	826
<i>methylphenidate hcl er oral tablet</i>	778	<i>neomycin-polymyxin-gramicidin</i>	827
<i>extendedrelease* 36 mg</i>	778	<i>neomycin-polymyxin-hc otic solution 3.5-10000-1</i>	827
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	774	.....	827
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	777	<i>neomycin-polymyxin-hc otic suspension</i>	828
<i>methylphenidate hcl oral tablet</i>	775	NEOSPORIN	829

NESINA	830	NUVIGIL ORAL TABLET 150 MG, 250 MG	878
NEUPRO	831	NUVIGIL ORAL TABLET 200 MG	877
NEURONTIN ORAL CAPSULE	832	NUVIGIL ORAL TABLET 50 MG	879
NEURONTIN ORAL TABLET	833	NYMALIZE	880
NEUTEK 2TEK TEST	834	OCELLA	881
NEVANAC	835	OCUFEN	882
NEXAVAR	836	OCUFLOX	883
NEXGEN TEST	837	ODOMZO	884
NEXIUM ORAL CAPSULE DELAYED RELEASE 40 MG	839	OFEV	885
NEXIUM ORAL PACKET	838	<i>ofloxacin ophthalmic</i>	886
NEXPLANON	840	<i>ofloxacin oral</i>	888
NEXT CHOICE	841	<i>ofloxacin otic</i>	887
NEXT CHOICE ONE DOSE	842	<i>olanzapine oral tablet 2.5 mg</i>	890
NICODERM CQ	843	<i>olanzapine oral tablet 20 mg, 7.5 mg, 10 mg, 15 mg, 5 mg</i>	889
NICORETTE MINI	846	<i>olanzapine oral tablet dispersible</i>	889
NICORETTE MOUTH/THROAT GUM	844	<i>olanzapine-fluoxetine hcl</i>	891
NICORETTE MOUTH/THROAT LOZENGE	845	OLUX	892
<i>nicotine</i>	847	OLUX-E	893
<i>nicotine polacrilex mouth/throat</i>	848	<i>omega-3-acid ethyl esters</i>	894
NICOTROL	849	<i>omeprazole oral capsule delayed release 10 mg, 40 mg</i>	895
NICOTROL NS	850	<i>omeprazole-sodium bicarbonate oral capsule 40-1100 mg</i>	896
NORA-BE	851	OMNIFLEX DIAPHRAGM	897
<i>norethindrone oral</i>	852	ON CALL EXPRESS BLOOD GLUCOSE	898
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	853	ON CALL PLUS BLOOD GLUCOSE	899
<i>norgestimate-eth estradiol</i>	854	ON CALL VIVID BLOOD GLUCOSE	900
<i>norgestim-eth estrad triphasic</i>	855	<i>ondansetron</i>	901
<i>norgestrel-ethinyl estradiol</i>	856	<i>ondansetron</i>	902
NOROXIN	857	<i>ondansetron hcl oral solution</i>	905
NOR-QD	858	<i>ondansetron hcl oral tablet 24 mg</i>	903
NORTHERA ORAL CAPSULE 100 MG	859	<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	904
NORTHERA ORAL CAPSULE 200 MG, 300 MG	860	ONETOUCH TEST	906
NORTREL 0.5/35 (28)	861	ONETOUCH ULTRA BLUE	907
NORTREL 1/35 (21)	862	ONETOUCH VERIO IN VITRO STRIP	908
NORTREL 1/35 (28)	863	ONEXTON	909
NORTREL 7/7/7	864	ONFI ORAL TABLET 10 MG, 20 MG	910
NORVASC	865	ONGLYZA	911
NOVA MAX GLUCOSE TEST	866	ONMEL	912
NOVOLIN 70/30	867	OPANA ER ORAL	913
NOVOLIN 70/30 RELION	868	OPSUMIT	914
NOVOLIN N	869	OPTIONS CONCEPTROL	915
NOVOLIN N RELION	870	OPTIONS GYNOL II CONTRACEPTIVE	916
NOVOLIN R	871	OPTIUM TEST	917
NOVOLIN R RELION	872	OPTIUMEZ TEST	918
NUCYNTA	873	OPTUMRX BLOOD GLUCOSE TEST	919
NUCYNTA ER	874	ORACEA	920
NUDEXTA	875	ORAVIG	921
NUVARING	876	ORKAMBI	922

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ORSYTHIA .....	923	PLEXION .....	966
ORTHO DIAPHRAGM COIL .....	924	PLEXION CLEANSER EXTERNAL LIQUID†	967
ORTHO DIAPHRAGM FLAT .....	925	.....	967
ORTHO EVRA .....	926	PLEXION CLEANSING CLOTH EXTERNAL	968
ORTHO MICRONOR .....	927	PAD .....	968
OSENI .....	928	POCKETCHEM EZ TEST .....	969
OXTELLAR XR ORAL TABLET EXTENDED		<i>polymyxin b-trimethoprim</i> .....	970
RELEASE 24 HR* 150 MG, 300 MG .....	929	POLYTRIM .....	971
OXTELLAR XR ORAL TABLET EXTENDED		POMALYST .....	972
RELEASE 24 HR* 600 MG .....	930	PORTIA-28 .....	973
<i>oxycodone hcl er</i> .....	931	POTIGA ORAL TABLET 200 MG, 300 MG, 400	
<i>oxycodone-ibuprofen</i> .....	932	MG .....	974
OXYCONTIN .....	933	PRADAXA .....	975
<i>oxymorphone hcl er</i> .....	934	PRALUENT .....	976
<i>paliperidone er oral tablet extended release 24 hr*</i>		<i>pramipexole dihydrochloride er oral tablet</i>	
<i>1.5 mg, 6 mg, 3 mg</i> .....	935	<i>extended release 24 hr* 4.5 mg</i> .....	977
<i>paliperidone er oral tablet extended release 24 hr*</i>		PRANDIN .....	978
<i>9 mg</i> .....	936	PRAVACHOL .....	979
<i>pantoprazole sodium oral</i> .....	937	<i>pravastatin sodium</i> .....	980
PARAGARD INTRAUTERINE COPPER .....	938	PRECISION PCX .....	981
<i>paroxetine hcl er</i> .....	941	PRECISION PCX PLUS TEST .....	982
<i>paroxetine hcl oral tablet 10 mg, 20 mg</i> .....	939	PRECISION POINT OF CARE TEST .....	983
<i>paroxetine hcl oral tablet 30 mg, 40 mg</i> .....	940	PRECISION QID TEST .....	984
PATANOL .....	942	PRECISION SOF-TACT TEST .....	985
PAXIL CR .....	946	PRECISION XTRA BLOOD GLUCOSE .....	986
PAXIL ORAL SUSPENSION .....	945	PRED-G .....	987
PAXIL ORAL TABLET 20 MG, 10 MG .....	943	PREFEST .....	988
PAXIL ORAL TABLET 30 MG, 40 MG .....	944	PRENTIF CAVITY-RIM CERV CAP .....	989
PENLAC .....	947	PRENTIF FITTING SET .....	990
PENNSAID TRANSDERMAL SOLUTION 1.5 %		<i>prestige smart system test</i> .....	991
.....	948	PRESTIGE TEST .....	992
PENNSAID TRANSDERMAL SOLUTION 2 %		PRESTIGE VALUE PACK .....	993
.....	949	PREVACID ORAL CAPSULE DELAYED	
PENTASA ORAL CAPSULE EXTENDED		RELEASE 30 MG .....	994
RELEASE* 250 MG .....	950	PREVACID SOLUTAB .....	997
PENTASA ORAL CAPSULE EXTENDED		PREVIFEM .....	1000
RELEASE* 500 MG .....	951	PRILOSEC ORAL CAPSULE DELAYED	
PERFOROMIST .....	952	RELEASE .....	1001
PERTZYE .....	953	PRILOSEC ORAL PACKET .....	1004
PEXEVA ORAL TABLET 10 MG, 20 MG .....	954	PRILOSEC OTC .....	1007
PEXEVA ORAL TABLET 40 MG, 30 MG .....	955	PRISTIQ .....	1008
PHARMACIST CHOICE AUTOCODE .....	956	PRISTIQ .....	1009
PHILITH .....	957	PROAIR HFA .....	1010
PICATO .....	958	PROAIR RESPICLICK .....	1011
PIMTREA .....	959	PROCENTRA .....	1012
PIRMELLA 1/35 .....	960	PROCYSBI ORAL CAPSULE DELAYED	
PIRMELLA 7/7/7 .....	961	RELEASE 25 MG .....	1013
PLAQUENIL .....	962	PROCYSBI ORAL CAPSULE DELAYED	
PLAVIX ORAL TABLET 75 MG .....	963	RELEASE 75 MG .....	1014
PLEGRIDY .....	964	PRODIGY AUTOCODE BLOOD GLUCOSE IN	
PLEGRIDY STARTER PACK .....	965	VITRO .....	1015

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PRODIGY NO CODING BLOOD GLUC	1016	RELISTOR SUBCUTANEOUS* SOLUTION 8	
<i>promethazine hcl oral</i>	1017	MG/0.4ML	1062
<i>promethazine hcl suppository 12.5 mg, 25 mg</i>		RELPAK	1065
	1017	REMERON	1066
<i>promethazine-codeine</i>	1018	REMERON SOLTAB	1067
<i>promethazine-dm</i>	1019	REPATHA	1068
PROMETHEGAN	1020	REPATHA SURECLICK	1069
PROTONIX ORAL	1021	REQUIP XL ORAL TABLET EXTENDED	
PROTONIX ORAL	1024	RELEASE 24 HR* 12 MG	1071
PROTOPIC	1027	REQUIP XL ORAL TABLET EXTENDED	
PROVENTIL HFA	1028	RELEASE 24 HR* 6 MG, 8 MG, 4 MG, 2 MG	
PROVIGIL	1029		1070
PROZAC ORAL CAPSULE 10 MG	1032	RESCULA	1072
PROZAC ORAL CAPSULE 20 MG	1031	RETIN-A	1073
PROZAC ORAL CAPSULE 40 MG	1030	RETIN-A MICRO	1074
PROZAC WEEKLY	1033	RETIN-A MICRO PUMP EXTERNAL 0.1 %,	
PTS PANELS GLUCOSE TEST	1034	0.04 %	1075
PULMICORT FLEXHALER	1035	REVATIO ORAL SUSPENSION	
QUALAQUIN	1036	RECONSTITUTED	1076
QUASENSE	1037	REVATIO ORAL TABLET	1077
QUDEXY XR	1038	REVEAL BLOOD GLUCOSE TEST	1078
<i>quetiapine fumarate oral tablet 100 mg, 50 mg</i>		REXALL BLOOD GLUCOSE TEST	1079
	1039	REXULTI	1080
<i>quetiapine fumarate oral tablet 200 mg</i>	1041	RHINOCORT AQUA	1081
<i>quetiapine fumarate oral tablet 25 mg</i>	1042	RIAX	1082
<i>quetiapine fumarate oral tablet 300 mg, 400 mg</i>		RIGHTEST GS100 BLOOD GLUCOSE	1083
	1040	RIGHTEST GS300 BLOOD GLUCOSE	1084
QUICKTEK TEST	1043	RIGHTEST GS550 BLOOD GLUCOSE	1085
QUILLIVANT XR	1044	RILUTEK	1086
<i>quinine sulfate oral</i>	1045	<i>riluzole</i>	1087
QUINTET AC BLOOD GLUCOSE TEST	1046	<i>risedronate sodium oral tablet 150 mg</i>	1090
QUINTET BLOOD GLUCOSE TEST	1047	<i>risedronate sodium oral tablet 35 mg</i>	1089
RA TRUETEST TEST	1048	<i>risedronate sodium oral tablet 5 mg, 30 mg</i>	1088
<i>rabeprazole sodium</i>	1049	RISPERDAL M-TAB ORAL TABLET	
RANEXA ORAL TABLET EXTENDED		DISPERSIBLE 3 MG, 0.5 MG, 1 MG, 2 MG	
RELEASE 12 HR* 1000 MG	1050		1094
RANEXA ORAL TABLET EXTENDED		RISPERDAL M-TAB ORAL TABLET	
RELEASE 12 HR* 500 MG	1051	DISPERSIBLE 4 MG	1095
RAPAFLO	1052	RISPERDAL ORAL SOLUTION	1093
RAYOS	1053	RISPERDAL ORAL TABLET 1 MG, 0.5 MG, 3	
RECLAST	1054	MG, 0.25 MG, 2 MG	1092
RECLIPSEN	1055	RISPERDAL ORAL TABLET 4 MG	1091
REFUAH PLUS BLOOD GLUCOSE TEST	1056	RISPERIDONE M-TAB ORAL TABLET	
RELENZA DISKHALER	1057	DISPERSIBLE 1 MG, 3 MG, 2 MG, 0.5 MG	
RELION BLOOD GLUCOSE TEST	1058		1098
RELION CONFIRM/MICRO TEST	1059	RISPERIDONE M-TAB ORAL TABLET	
RELION PRIME TEST	1060	DISPERSIBLE 4 MG	1099
RELION ULTIMA TEST	1061	<i>risperidone oral tablet 0.25 mg, 2 mg, 0.5 mg, 1</i>	
RELISTOR SUBCUTANEOUS* KIT	1063	<i>mg, 3 mg</i>	1096
RELISTOR SUBCUTANEOUS* SOLUTION 12		<i>risperidone oral tablet 4 mg</i>	1097
MG/0.6ML	1064		

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<i>risperidone oral tablet dispersible 3 mg, 0.25 mg, 1 mg, 0.5 mg, 2 mg</i> .....	1096	<i>sildenafil citrate oral</i> .....	1138
<i>risperidone oral tablet dispersible 4 mg</i> .....	1097	SILENOR.....	1139
RITALIN.....	1100	SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 1000-40 MG, 500-40 MG	1140
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 40 MG, 20 MG	1101	SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 500-20 MG, 750-20 MG, 1000-20 MG.....	1141
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 30 MG.....	1103	SIMPONI.....	1142
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 60 MG.....	1102	<i>simvastatin oral</i> .....	1143
RITALIN SR.....	1104	SINGULAIR.....	1144
<i>rizatriptan benzoate</i> .....	1105	SINGULAIR.....	1145
<i>rizatriptan benzoate</i> .....	1106	SIRTURO.....	1146
<i>ropinirole hcl er oral tablet extended release 24 hr* 12 mg</i> .....	1108	SIVEXTRO ORAL.....	1148
<i>ropinirole hcl er oral tablet extended release 24 hr* 4 mg, 2 mg, 6 mg, 8 mg</i> .....	1107	SKELID.....	1149
ROZEREM.....	1109	SKYLA.....	1150
SABRIL ORAL TABLET.....	1110	SMART DIABETES XPRES TEST.....	1151
SANCTURA.....	1111	SMART SENSE PREMIUM TEST.....	1152
SANCUSO.....	1112	SMART SENSE VALUE TEST.....	1153
SAPHRIS.....	1113	SMARTEST BLOOD GLUCOSE TEST.....	1154
SAPHRIS.....	1114	SOLIA.....	1155
SAVAYSA.....	1115	SOLODYN.....	1156
SAVELLA.....	1116	SOLUS V2 TEST.....	1157
SAVELLA TITRATION PACK.....	1117	SONATA ORAL CAPSULE 10 MG.....	1159
SEASONIQUE.....	1118	SONATA ORAL CAPSULE 5 MG.....	1158
SEMPREX-D.....	1119	SOOLANTRA.....	1160
<i>sentry test</i> .....	1121	SORILUX.....	1161
SEREVENT DISKUS.....	1122	SPIRIVA HANDIHALER.....	1162
SEROQUEL ORAL TABLET 100 MG, 50 MG	1126	SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 1.25 MCG/ACT.....	1163
SEROQUEL ORAL TABLET 200 MG.....	1124	SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 2.5 MCG/ACT.....	1164
SEROQUEL ORAL TABLET 25 MG.....	1125	SPORANOX.....	1165
SEROQUEL ORAL TABLET 300 MG, 400 MG	1123	SPORANOX PULSEPAK.....	1167
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 200 MG.....	1127	SPRINTEC 28.....	1169
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 300 MG, 400 MG.....	1128	SPRIX.....	1170
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 50 MG.....	1129	SPRYCEL.....	1171
<i>sertraline hcl oral concentrate</i> .....	1132	SRONYX.....	1172
<i>sertraline hcl oral tablet 100 mg</i> .....	1130	STIMATE.....	1173
<i>sertraline hcl oral tablet 25 mg</i> .....	1133	STIOLTO RESPIMAT.....	1174
<i>sertraline hcl oral tablet 50 mg</i> .....	1131	STRATTERA ORAL CAPSULE 100 MG, 80 MG	1176
<i>shoprite test</i> .....	1134	STRATTERA ORAL CAPSULE 25 MG, 10 MG, 18 MG, 40 MG, 60 MG.....	1175
SHUR-SEAL CONTRACEPTIVE.....	1135	STRIANT.....	1177
SIGNIFOR.....	1136	STRIBILD.....	1178
SIGNIFOR LAR.....	1137	STRIVERDI RESPIMAT.....	1179
		SUBOXONE SUBLINGUAL FILM 12-3 MG	1183
		SUBOXONE SUBLINGUAL FILM 8-2 MG, 2-0.5 MG, 4-1 MG.....	1180

SUBOXONE SUBLINGUAL TABLET		<i>testosterone transdermal 10 mg/act (2%)</i> .....	1235
SUBLINGUAL.....	1182	<i>testosterone transdermal 12.5 mg/act (1%)</i> .....	1234
SUBSYS SUBLINGUAL LIQUID† 100 MCG		<i>testosterone transdermal 25 mg/2.5gm (1%)</i> .....	1232
.....	1189	<i>testosterone transdermal 50 mg/5gm (1%)</i> .....	1233
SUBSYS SUBLINGUAL LIQUID† 1600 (800 X		<i>tetrabenazine oral tablet 12.5 mg</i> .....	1237
2) MCG, 1200 (600 X 2) MCG.....	1185	<i>tetrabenazine oral tablet 25 mg</i> .....	1236
SUBSYS SUBLINGUAL LIQUID† 600 MCG,		TEVETEN HCT.....	1239
800 MCG, 400 MCG, 200 MCG.....	1187	TEVETEN ORAL TABLET 600 MG.....	1238
SUBUTEX.....	1191	<i>tgt blood glucose test</i> .....	1240
<i>sulfacetamide sodium ophthalmic solution</i> .....	1193	<i>tiagabine hcl oral tablet 2 mg</i> .....	1242
<i>sulfasalazine oral</i> .....	1194	<i>tiagabine hcl oral tablet 4 mg</i> .....	1241
SULFAZINE.....	1195	TILIA FE.....	1243
SULFAZINE EC.....	1196	TIVORBEX.....	1244
<i>sumatriptan succinate oral</i> .....	1197	TOBRADEX OPHTHALMIC SUSPENSION	
SUMAVEL DOSEPRO.....	1198	.....	1245
SUPREME TEST.....	1199	TOBRADEX ST.....	1246
SURE EDGE TEST.....	1200	<i>tobramycin ophthalmic</i> .....	1247
SURECHEK BLOOD GLUCOSE TEST.....	1201	<i>tobramycin-dexamethasone</i> .....	1248
SURESTEP PRO TEST.....	1202	TOBREX OPHTHALMIC SOLUTION.....	1249
SURESTEP TEST.....	1203	TODAY SPONGE.....	1250
SURE-TEST EASYPLUS MINI TEST.....	1204	TOPAMAX SPRINKLE.....	1251
SUTENT ORAL CAPSULE 50 MG, 25 MG, 12.5		<i>topiramate oral capsule sprinkle</i> .....	1252
MG.....	1205	TOVIAZ.....	1253
SYEDA.....	1206	TRADJENTA.....	1254
SYMBICORT.....	1207	<i>tramadol hcl er oral capsule extended release 24</i>	
SYMBYAX.....	1208	<i>hour 300 mg, 100 mg, 200 mg</i> .....	1255
SYMLINPEN 120.....	1209	<i>tranexamic acid oral</i> .....	1256
SYMLINPEN 60.....	1210	TRAVATAN Z.....	1257
SYNJARDY.....	1211	<i>travoprost</i> .....	1258
<i>tacrolimus external</i> .....	1212	<i>tretinoin external</i> .....	1259
TAFINLAR.....	1213	<i>tretinoin microsphere</i> .....	1261
TAMIFLU ORAL CAPSULE 30 MG, 45 MG		<i>tretinoin microsphere pump</i> .....	1262
.....	1214	<i>tretinoin oral</i> .....	1260
TAMIFLU ORAL CAPSULE 75 MG.....	1216	TRETIN-X EXTERNAL CREAM.....	1263
TAMIFLU ORAL SUSPENSION		TREXIMET.....	1264
RECONSTITUTED 6 MG/ML.....	1215	TREZIX ORAL CAPSULE 320.5-30-16 MG	
TANZEUM.....	1217	.....	1265
TARCEVA.....	1218	TRIBENZOR.....	1266
TARGADOX.....	1219	TRICOR.....	1267
TASIGNA.....	1221	TRI-ESTARYLLA.....	1268
TAZORAC.....	1222	<i>trifluridine ophthalmic</i> .....	1269
TECHNIVIE.....	1223	TRIGLIDE ORAL TABLET 160 MG.....	1270
TEKAMLO.....	1224	TRI-LEGEST FE.....	1271
TEKTURNA.....	1225	TRI-LINYAH.....	1272
TEKTURNA HCT ORAL TABLET 150-25 MG,		TRILIPIX.....	1273
150-12.5 MG.....	1226	TRINESSA (28).....	1274
TELCARE BLOOD GLUCOSE TEST.....	1227	TRI-PREVIFEM.....	1275
TEMODAR ORAL.....	1228	TRI-SPRINTEC.....	1276
<i>temozolomide</i> .....	1229	TRIVORA (28).....	1277
<i>terbinafine hcl oral</i> .....	1230	TROKENDI XR ORAL CAPSULE EXTENDED	
TESTIM.....	1231	RELEASE 24 HOUR 200 MG.....	1279

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TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 25 MG, 50 MG, 100 MG	1278	VICTORY AGM-4000 TEST	1320
<i>trospium chloride</i>	1280	VICTOZA	1321
<i>trospium chloride er</i>	1281	VICTRELIS	1322
<i>true care test strip pack</i>	1282	VIGAMOX	1323
TRUETEST TEST	1283	VIIBRYD	1324
TRUETRACK TEST	1284	VIIBRYD	1325
TRULICITY	1285	VIIBRYD STARTER PACK	1326
TRUVADA	1286	VIMOVO	1327
TUDORZA PRESSAIR	1287	VIMPAT ORAL SOLUTION	1329
TWINJECT INJECTION 0.15 MG/0.15ML	1288	VIMPAT ORAL TABLET 200 MG, 150 MG, 100 MG	1328
TYBOST	1289	VIMPAT ORAL TABLET 50 MG	1330
TYKERB	1290	VIOKACE	1331
UCERIS	1292	<i>viorele</i>	1332
UCERIS ORAL	1291	VIRAMUNE	1333
ULORIC	1293	VIROPTIC	1334
ULTIMA TEST	1294	VIVELLE-DOT	1335
ULTRATRAK PRO TEST	1295	VOCAL POINT BLOOD GLUCOSE TEST	1336
ULTRATRAK ULTIMATE TEST	1296	VOGELXO	1337
ULTRESA	1297	VOGELXO PUMP	1338
UNISTRIP1 GENERIC	1298	VOLTAREN TRANSDERMAL	1339
VALCYTE ORAL SOLUTION RECONSTITUTED	1299	VOTRIENT	1340
VALCYTE ORAL TABLET	1300	VYFEMLA	1341
<i>valganciclovir hcl</i>	1301	VYTORIN	1342
<i>valsartan-hydrochlorothiazide oral tablet 160-25 mg, 160-12.5 mg, 80-12.5 mg</i>	1302	VYVANSE	1343
VALTREX	1303	VYVANSE	1344
VASCEPA	1304	WAVESENSE PRESTO	1345
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM	1305	WELLBUTRIN	1346
VCF VAGINAL CONTRACEPTIVE VAGINAL FOAM	1305	WELLBUTRIN SR	1347
VECAMYL	1306	WELLBUTRIN XL	1348
VELIVET	1307	WERA	1349
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg</i>	1314	WIDE-SEAL DIAPHRAGM 60	1350
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg, 37.5 mg</i>	1312	WIDE-SEAL DIAPHRAGM 65	1351
<i>venlafaxine hcl er oral tablet extended release 24 hr* 225 mg</i>	1313	WIDE-SEAL DIAPHRAGM 70	1352
<i>venlafaxine hcl oral tablet 25 mg, 100 mg</i>	1308	WIDE-SEAL DIAPHRAGM 75	1353
<i>venlafaxine hcl oral tablet 37.5 mg</i>	1310	WIDE-SEAL DIAPHRAGM 80	1354
<i>venlafaxine hcl oral tablet 50 mg</i>	1311	WIDE-SEAL DIAPHRAGM 85	1355
<i>venlafaxine hcl oral tablet 75 mg</i>	1309	WIDE-SEAL DIAPHRAGM 90	1356
VENTOLIN HFA	1315	WIDE-SEAL DIAPHRAGM 95	1357
VERDESO	1316	<i>winn dixie medic test</i>	1358
VERSACLOZ	1317	WYMZYA FE	1359
VESTURA	1318	XALATAN	1360
VIBRAMYCIN	1319	XALKORI	1361
		XANAX XR	1362
		XARELTO ORAL TABLET 10 MG	1363
		XARELTO ORAL TABLET 15 MG	1364
		XARELTO ORAL TABLET 20 MG	1365
		XARELTO STARTER PACK	1366
		XARTEMIS XR	1367
		XELJANZ	1368
		XELODA	1369

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XENAZINE ORAL TABLET 12.5 MG	1370	<i>zolpidem tartrate er</i>	1425
XENAZINE ORAL TABLET 25 MG	1371	<i>zolpidem tartrate oral tablet 10 mg</i>	1424
XIFAXAN ORAL TABLET 200 MG	1373	<i>zolpidem tartrate oral tablet 5 mg</i>	1423
XIFAXAN ORAL TABLET 550 MG	1372	ZOLPIMIST	1426
XIGDUO XR	1374	ZOMETA INTRAVENOUS* CONCENTRATE	
XOPENEX HFA	1375		1428
XTANDI	1376	ZOMETA INTRAVENOUS* SOLUTION	1427
XULANE	1377	ZOMIG NASAL SOLUTION 2.5 MG	1429
XYREM	1378	ZOMIG NASAL SOLUTION 5 MG	1430
XYZAL ORAL SOLUTION	1379	ZOMIG ORAL	1431
XYZAL ORAL TABLET	1381	ZOMIG ZMT	1432
<i>zaleplon oral capsule 10 mg</i>	1383	ZORVOLEX	1433
<i>zaleplon oral capsule 5 mg</i>	1384	ZOVIA 1/35E (28)	1434
ZARAH	1385	ZOVIA 1/50E (28)	1435
ZECUITY	1386	ZUBSOLV SUBLINGUAL TABLET	
ZEGERID ORAL CAPSULE 40-1100 MG	1387	SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG	1436
ZEGERID ORAL PACKET	1390	ZUBSOLV SUBLINGUAL TABLET	
ZELAPAR	1393	SUBLINGUAL 11.4-2.9 MG	1438
ZELBORAF	1394	ZUBSOLV SUBLINGUAL TABLET	
ZENATANE ORAL CAPSULE 20 MG, 10 MG, 40 MG	1395	SUBLINGUAL 2.9-0.71 MG	1440
ZENCHENT	1396	ZUBSOLV SUBLINGUAL TABLET	
ZENCHENT FE	1397	SUBLINGUAL 8.6-2.1 MG	1442
ZENZEDI	1398	ZUPLENZ	1444
ZENZEDI	1399	ZYBAN	1445
ZEOSA	1400	ZYCLARA	1446
ZERIT	1401	ZYCLARA PUMP EXTERNAL CREAM 2.5 %	
ZETIA	1402		1448
ZETONNA	1403	ZYCLARA PUMP EXTERNAL CREAM 3.75 %	
ZIAGEN	1404		1447
ZIOPTAN	1405	ZYLET	1449
<i>ziprasidone hcl</i>	1406	ZYMAXID	1450
ZOCOR	1407	ZYPREXA ORAL TABLET 10 MG, 5 MG, 15 MG, 7.5 MG, 20 MG	1451
ZOFRAN ODT	1410	ZYPREXA ORAL TABLET 2.5 MG	1452
ZOFRAN ORAL SOLUTION	1408	ZYPREXA ZYDIS	1453
ZOFRAN ORAL TABLET	1409	ZYTIGA	1454
ZOHYDRO ER ORAL	1411		
ZOHYDRO ER ORAL CAPSULE EXTENDED RELEASE 12 HOUR	1413		
<i>zoledronic acid intravenous* concentrate</i>	1414		
<i>zoledronic acid intravenous* solution 5 mg/100ml</i>	1415		
ZOLINZA	1416		
<i>zolmitriptan oral tablet 2.5 mg</i>	1418		
<i>zolmitriptan oral tablet 5 mg</i>	1417		
<i>zolmitriptan oral tablet dispersible 2.5 mg</i>	1418		
<i>zolmitriptan oral tablet dispersible 5 mg</i>	1417		
ZOLOFT ORAL CONCENTRATE	1421		
ZOLOFT ORAL TABLET 100 MG	1420		
ZOLOFT ORAL TABLET 25 MG	1419		
ZOLOFT ORAL TABLET 50 MG	1422		

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