Abilify

Products Affected

- ABILIFY ORAL SOLUTION

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

Abilify

Products Affected

- ABILIFY ORAL TABLET

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

Acamprosate Calcium

Products Affected

- *acamprosate calcium*

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

Accu-Chek Active

Products Affected

- ACCU-CHEK ACTIVE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Aviva

Products Affected

- ACCU-CHEK AVIVA IN VITRO STRIP

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Aviva Plus

Products Affected

- ACCU-CHEK AVIVA PLUS IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Comfort Curve

Products Affected

- ACCU-CHEK COMFORT CURVE IN VITRO STRIP

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Compact

Products Affected

- ACCU-CHEK COMPACT

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Compact Plus

Products Affected

- ACCU-CHEK COMPACT PLUS

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Compact Test Drum

Products Affected

- ACCU-CHEK COMPACT TEST DRUM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek SmartView

Products Affected

- ACCU-CHEK SMARTVIEW

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accutrend Glucose

Products Affected

- ACCUTREND GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aciphex

Products Affected

- ACIPHEX

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	Rabeprazole up to 20 mg/day, Dexilant up to 60 mg/day, and Nexium up to 40 mg/day are available with prior-authorization when the following criteria is met: Step through Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. High Dose Nexium, Rabeprazole and Prevacid solutabs are available with prior-authorization when the following criteria is met: Nexium up to 80mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Rabeprazole up to 40mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Prevacid solutabs up to 60mg/day for members greater than 1 year old with documentation of: inability to swallow tablets/capsules and step through ONE of the following: 80mg/day of omeprazole (capsules may be opened and sprinkled on 1 tablespoon of applesauce), or 60mg/day of Prevacid 24H OTC (capsule may be opened and sprinkled on 1 tablespoon of applesauce, Ensure pudding, cottage cheese, yogurt, or strained pears, or emptied into 60mL of apple juice, orange juice, or tomato juice)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short Term course of high dose PPI 3-6 months. Long term course up to 1 Year.

PA Criteria	Criteria Details
Other Criteria	A step through one of these high dose therapies (80mg/day of Prilosec OTC/omeprazole or pantoprazole, OR 60mg/day of Prevacid 24H OTC) is required even if the member was previously approved for Rabeprazole, Prevacid solutabs, or Nexium at standard dosing. Exceptions may be considered if there is documentation of intolerance, e.g., side-effects or allergies to Prilosec OTC/omeprazole, pantoprazole, and Prevacid 24H OTC.
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acitretin

Products Affected

- *acitretin*

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

Actemra

Products Affected

- ACTEMRA INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/actimmune.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actonel

Products Affected

- ACTONEL ORAL TABLET 30 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actonel

Products Affected

- ACTONEL ORAL TABLET 35 MG

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.15 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Actoplus met XR

Products Affected

- ACTOPLUS MET XR

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	2 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acura Blood Glucose Test

Products Affected

- ACURA BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acuvail

Products Affected

- ACUVAIL

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

Adapalene

Products Affected

- *adapalene*

ST Criteria	Documented step through TRETINOIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adcirca

Products Affected

- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adefovir Dipivoxil

Products Affected

- *adefovir dipivoxil*

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

Advair Diskus

Products Affected

- ADVAIR DISKUS

ST Criteria	Documented step through DULERA (covered without trials for COPD)
QL Criteria	1 diskus Per 1 Fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advair HFA

Products Affected

- ADVAIR HFA

ST Criteria	Documented step through DULERA (covered without trials for COPD)
QL Criteria	1 inhaler Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advance Intuition Test

Products Affected

- ADVANCE INTUITION TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advate

Products Affected

- ADVATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advicor

Products Affected

- ADVICOR ORAL TABLET EXTENDED RELEASE 24 HR* 1000-40 MG, 500-20 MG

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advicor

Products Affected

- ADVICOR ORAL TABLET EXTENDED RELEASE 24 HR* 1000-20 MG

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advicor

Products Affected

- ADVICOR ORAL TABLET EXTENDED RELEASE 24 HR* 750-20 MG

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Redi-Code

Products Affected

- ADVOCATE REDI-CODE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Redi-Code Duo Talking

Products Affected

- ADVOCATE REDI-CODE DUO TALKING

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

Advocate Redi-Code+ Test

Products Affected

- ADVOCATE REDI-CODE+ TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Test

Products Affected

- ADVOCATE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Afeditab CR

Products Affected

- AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG

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

Afeditab CR

Products Affected

- AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG

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

Afinitor

Products Affected

- AFINITOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix AMP Test

Products Affected

- AGAMATRIX AMP TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix Jazz Test

Products Affected

- AGAMATRIX JAZZ TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix KeyNote Test

Products Affected

- AGAMATRIX KEYNOTE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix Presto Test

Products Affected

- AGAMATRIX PRESTO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aggrenox

Products Affected

- AGGRENOX

ST Criteria	Documented step through CLOPIDOGREL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aldurazyme

Products Affected

- ALDURAZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alendronate Sodium

Products Affected

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

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

Alendronate Sodium

Products Affected

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

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

Alfuzosin HCl ER

Products Affected

- *alfuzosin hcl er*

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

Alimta

Products Affected

- ALIMTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alinia

Products Affected

- ALINIA ORAL TABLET

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

Alinia

Products Affected

- ALINIA ORAL SUSPENSION RECONSTITUTED

QL Criteria	180 SUSR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Almotriptan Malate

Products Affected

- *almotriptan malate*

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	6 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alora

Products Affected

- ALORA

QL Criteria	0.29 patches Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alora

Products Affected

- ALORA

QL Criteria	0.29 PTTW Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aloxi

Products Affected

- ALOXI

PA Criteria	Criteria Details
Covered Uses	Prevention of acute or delayed nausea or vomiting associated with initial and repeat courses of moderately and highly emetogenic cancer chemotherapy and prevention of postoperative nausea and vomiting (PONV) for up to 24 hours following surgery
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alphanate/VWF Complex/Human

Products Affected

- ALPHANATE/VWF COMPLEX/HUMAN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AlphaNine SD

Products Affected

- ALPHANINE SD

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

Alprolix

Products Affected

- ALPROLIX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Altavera

Products Affected

- ALTAVERA

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

Altoprev

Products Affected

- ALTOPREV

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

Alvesco

Products Affected

- ALVESCO

ST Criteria	Documented step through QVAR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alyacen 1/35

Products Affected

- *alyacen 1/35*

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

Amethia

Products Affected

- AMETHIA

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

Amethia Lo

Products Affected

- AMETHIA LO

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

Amethyst

Products Affected

- AMETHYST

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

Amitiza

Products Affected

- AMITIZA

ST Criteria	Documented step through LACTULOSE OR POLYETHYLENE GLYCOL
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

Amlodipine Besy-Benazepril HCl

Products Affected

- *amlodipine besy-benazepril hcl*

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

Amlodipine Besylate-Valsartan

Products Affected

- *amlodipine besylate-valsartan*

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

Amlodipine-Valsartan-HCTZ

Products Affected

- *amlodipine-valsartan-hctz*

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

Amnesteem

Products Affected

- AMNESTEEM

ST Criteria	Documented step through MINOCYCLINE OR DOXYCYCLINE
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

Amoxicillin-Pot Clavulanate ER

Products Affected

- *amoxicillin-pot clavulanate er*

QL Criteria	40 TB12 Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	

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

Amphetamine-Dextroamphetamine

Products Affected

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

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

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine oral tablet*
  30 mg, 12.5 mg

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

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine oral tablet 20 mg*

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

Ampyra

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amturnide

Products Affected

- AMTURNIDE

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

Androderm

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24 HR 2 MG/24HR

QL Criteria	1 PT24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Androderm

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24 HR 4 MG/24HR

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	1 PT24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

- ANDROGEL TRANSDERMAL 40.5 MG/2.5GM (1.62%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	75 GEL Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	37.5 GEL Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

- ANDROGEL TRANSDERMAL 50 MG/5GM (1%), 25 MG/2.5GM (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	5 GEL Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel Pump

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	5 GEL Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel Pump

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	75 GEL Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Anzemet

Products Affected

- ANZEMET ORAL

QL Criteria	0.17 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apidra

Products Affected

- APIDRA

ST Criteria	Documented step through HUMALOG product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apidra SoloStar

Products Affected

- APIDRA SOLOSTAR

ST Criteria	Documented step through HUMALOG product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apri

Products Affected

- APRI

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

Apriso

Products Affected

- APRISO

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

Aralast NP

Products Affected

- ARALAST NP

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

Aranelle

Products Affected

- ARANELLE

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

Aranesp (Albumin Free)

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arcapta Neohaler

Products Affected

- ARCAPTA NEOHALER

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	The use in acute bronchospasm, in the treatment of asthma, and in the use in patients under 18 years of age.
Required Medical Information	Patients with documented diagnosis of chronic obstructive pulmonary disease (COPD), or documented physical limitation that prevents the use of a non-nebulized long-acting bronchodilator with or without use of a spacer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Approval: 1 year. Extended Approval: 3 years.
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ARIPiprazole

Products Affected

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

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

ARIPiprazole

Products Affected

- *aripiprazole oral solution*

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

Arzerra

Products Affected

- ARZERRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	Aetna considers ofatumumab experimental and investigational for the treatment of the following indications (not an all inclusive list) because its effectiveness for these indications has not been established: Autoimmune diseases, B-cell lymphomas (other than CLL/SLL), including diffuse large B cell lymphoma, follicular lymphoma, and mantle cell lymphoma, Crohn's disease, Multiple sclerosis, Paraneoplastic opsoclonus-myoclonus/opsoclonus-myoclonus syndrome, Rheumatoid arthritis, Systemic lupus erythematosus, Vasculitis, Wegener's granulomatosis.
Required Medical Information	Aetna considers ofatumumab (Arzerra) medically necessary for the treatment of individuals with the following indications: (1)Previously untreated persons with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) for whom fludarabine-based therapy is considered inappropriate, (2)Relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), (3)Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR
Other Criteria	Chronic lymphocytic leukemia (CLL) refractory to fludarabine(Fludara) and alemtuzumab(Campath)
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asacol

Products Affected

- ASACOL

ST Criteria	Documented failure, contraindication, or intolerance to APRISO
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asacol HD

Products Affected

- ASACOL HD

ST Criteria	Documented failure, contraindication, or intolerance to APRISO
QL Criteria	6 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ascensia Autodisc Test

Products Affected

- ASCENSIA AUTODISC TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asmanex 120 Metered Doses

Products Affected

- ASMANEX 120 METERED DOSES

ST Criteria	Documented step through QVAR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asmanex 14 Metered Doses

Products Affected

- ASMANEX 14 METERED DOSES

ST Criteria	Documented step through QVAR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asmanex 30 Metered Doses

Products Affected

- ASMANEX 30 METERED DOSES

ST Criteria	Documented step through QVAR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asmanex 60 Metered Doses

Products Affected

- ASMANEX 60 METERED DOSES

ST Criteria	Documented step through QVAR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure 3 Test

Products Affected

- ASSURE 3 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure 4 Test

Products Affected

- ASSURE 4 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure Platinum

Products Affected

- ASSURE PLATINUM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure Pro Test

Products Affected

- ASSURE PRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atelvia

Products Affected

- ATELVIA

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.15 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

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

Atovaquone

Products Affected

- *atovaquone oral*

QL Criteria	210 SUSP Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atovaquone-Proguanil HCl

Products Affected

- *atovaquone-proguanil hcl*

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Prevention of malaria
Required Medical Information	Diagnosis of malaria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 days
Other Criteria	
QL Criteria	12 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atripla

Products Affected

- ATRIPLA

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

Atrovent HFA

Products Affected

- ATROVENT HFA

QL Criteria	1.04 AERS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aubagio

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Auvi-Q

Products Affected

- AUVI-Q

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

Avandamet

Products Affected

- AVANDAMET

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	Diagnosis of Type 1 Diabetes (IDDM), patients with symptomatic heart failure or those who develop signs and symptoms of heart failure after initiation of Avandia therapy, patients with established New York Heart Association (NYHA) Class III or IV heart failure, patients with a history of myocardial infarction, concurrent use with insulin or Symlin.
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus in an adult patient who is unable to achieve adequate glycemic control (HbA1C lab value greater than 6.5%) despite the use of other medications, and who, after consultation with their healthcare provider, has decided not to take Actos (pioglitazone) for medical reasons.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avandaryl

Products Affected

- AVANDARYL

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	Diagnosis of Type 1 Diabetes (IDDM), patients with symptomatic heart failure or those who develop signs and symptoms of heart failure after initiation of Avandia therapy, patients with established New York Heart Association (NYHA) Class III or IV heart failure, patients with a history of myocardial infarction, concurrent use with insulin or Symlin.
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus in an adult patient who is unable to achieve adequate glycemic control (HbA1C lab value greater than 6.5%) despite the use of other medications, and who, after consultation with their healthcare provider, has decided not to take Actos (pioglitazone) for medical reasons.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avandia

Products Affected

- AVANDIA

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	Diagnosis of Type 1 Diabetes (IDDM), patients with symptomatic heart failure or those who develop signs and symptoms of heart failure after initiation of Avandia therapy, patients with established New York Heart Association (NYHA) Class III or IV heart failure, patients with a history of myocardial infarction, concurrent use with insulin or Symlin.
Required Medical Information	A documented diagnosis of type 2 diabetes mellitus in an adult patient who is unable to achieve adequate glycemic control (HbA1C lab value greater than 6.5%) despite the use of other medications, and who, after consultation with their healthcare provider, has decided not to take Actos (pioglitazone) for medical reasons.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aviane

Products Affected

- AVIANE

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

Avita

Products Affected

- AVITA EXTERNAL CREAM

QL Criteria	1.67 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avonex

Products Affected

- AVONEX

PA Criteria	Criteria Details
Covered Uses	efer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.15 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Axert

Products Affected

- AXERT

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	0.2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Axiron

Products Affected

- AXIRON

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	90 SOLN Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Azilect

Products Affected

- AZILECT

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

Azor

Products Affected

- AZOR

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

Azurette

Products Affected

- AZURETTE

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

Balsalazide Disodium

Products Affected

- *balsalazide disodium*

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

Balziva

Products Affected

- BALZIVA

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

Banzel

Products Affected

- BANZEL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome
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

Banzel

Products Affected

- BANZEL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	8 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Baraclude

Products Affected

- BARACLUDE ORAL TABLET

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

Bayer Breeze 2 Test

Products Affected

- BAYER BREEZE 2 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bayer Contour Next Test

Products Affected

- BAYER CONTOUR NEXT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bayer Contour Test

Products Affected

- BAYER CONTOUR TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

BD Test

Products Affected

- BD TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bebulin VH

Products Affected

- BEBULIN VH

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Beconase AQ

Products Affected

- BECONASE AQ

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benicar

Products Affected

- BENICAR

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

Benicar HCT

Products Affected

- BENICAR HCT

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

Benlysta

Products Affected

- BENLYSTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/benlysta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Benzphetamine HCl

Products Affected

- *benzphetamine hcl*

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Bepreve

Products Affected

- BEPREVE

QL Criteria	0.1 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Betaseron

Products Affected

- BETASERON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.5 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Beyaz

Products Affected

- BEYAZ

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

BG Star Test

Products Affected

- BG STAR TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bicalutamide

Products Affected

- *bicalutamide*

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

Bivigam

Products Affected

- BIVIGAM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

BL Test Strip Pack

Products Affected

- *bl test strip pack*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Blood Glucose Test

Products Affected

- *blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bontril Slow Release

Products Affected

- BONTRIL SLOW RELEASE

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Bosulif

Products Affected

- BOSULIF ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bosulif

Products Affected

- BOSULIF ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Botox

Products Affected

- BOTOX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Brevicon (28)

Products Affected

- BREVICON (28)

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

Briellyn

Products Affected

- *briellyn*

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

Brilinta

Products Affected

- BRILINTA

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

Brilinta

Products Affected

- BRILINTA

ST Criteria	Documented step through CLOPIDOGREL
QL Criteria	2 tablets Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Brovana

Products Affected

- BROVANA

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	Documented physical limitation that prevents the use of a non-nebulized long-acting bronchodilator with or without use of a spacer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	4 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Budeprion SR

Products Affected

- BUDEPRION SR

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

Budeprion XL

Products Affected

- BUDEPRION XL

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

Budesonide

Products Affected

- *budesonide inhalation*

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	Budesonide inhalation solution is NOT covered for members greater than 8 years of age, for children 5-8 years of age who are able to use metered-dose inhalers, for use in primary treatment of status asthmaticus or other acute episodes of asthma where intensive measures are required, and for use in acute bronchospasms.
Required Medical Information	Covered for the maintenance treatment of asthma and as prophylactic therapy in children 1-4 years of age, or in children 5-8 years of age if unable to use metered dose inhalers.
Age Restrictions	Less than 8 years of age
Prescriber Restrictions	
Coverage Duration	1 Year, up to the age of 8 years of age
Other Criteria	Medical Exception: Covered for topical steroid treatment of eosinophilic esophagitis for which other treatments have been unsatisfactory
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual*

PA Criteria	Criteria Details
Covered Uses	Opioid Dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

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

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	Opioid Dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	3 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buproban

Products Affected

- BUPROBAN

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

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

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

BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

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

BuPROPion HCl ER (XL)

Products Affected

- *bupropion hcl er (xl)*

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

Butorphanol Tartrate

Products Affected

- *butorphanol tartrate nasal*

QL Criteria	0.17 SOL Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Butrans

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	0.15 PATCH Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bydureon

Products Affected

- BYDUREON SUBCUTANEOUS* SUSPENSION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	0.15 vials Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Byetta 10 MCG Pen

Products Affected

- BYETTA 10 MCG PEN

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	0.08 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Byetta 5 MCG Pen

Products Affected

- BYETTA 5 MCG PEN

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	0.04 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bystolic

Products Affected

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

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

Bystolic

Products Affected

- BYSTOLIC ORAL TABLET 20 MG

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

Calcipotriene

Products Affected

- *calcipotriene external*

ST Criteria	Documented step through of trial and failure of MEDIUM TO HIGH POTENCY TOPICAL STEROID
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.13 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Calcitrene

Products Affected

- CALCITRENE

ST Criteria	Documented step through of trial and failure of MEDIUM TO HIGH POTENCY TOPICAL STEROID
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Campral

Products Affected

- CAMPRAL

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

Camrese

Products Affected

- CAMRESE

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

Camrese Lo

Products Affected

- CAMRESE LO

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

Canasa

Products Affected

- CANASA

ST Criteria	Documented failure, contraindication, or intolerance to APRISO
QL Criteria	1 SUPP Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Candesartan Cilexetil

Products Affected

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

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

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz*

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

Capecitabine

Products Affected

- *capecitabine*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 300 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Carbaglu

Products Affected

- CARBAGLU

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

Cardura XL

Products Affected

- CARDURA XL

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

CareSens N Glucose Test

Products Affected

- CARESENS N GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Carimune NF

Products Affected

- CARIMUNE NF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cartia XT

Products Affected

- CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 180 MG, 120 MG

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

Cartia XT

Products Affected

- CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Caverject

Products Affected

- CAVERJECT

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

Caverject Impulse

Products Affected

- CAVERJECT IMPULSE

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

Cayston

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/pulmozyme.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 SOLR Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Caziant

Products Affected

- CAZIANT

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

Cefaclor ER

Products Affected

- *cefaclor er*

QL Criteria	14 TB12 Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cefixime

Products Affected

- *cefixime*

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

CeleBREX

Products Affected

- CELEBREX

ST Criteria	Documented step through TWO NSAIDs
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

Celecoxib

Products Affected

- *celecoxib oral*

ST Criteria	Documented step through TWO NSAIDs
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cenestin

Products Affected

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

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

Cenestin

Products Affected

- CENESTIN ORAL TABLET 1.25 MG

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

Cerezyme

Products Affected

- CEREZYME INTRAVENOUS* SOLUTION RECONSTITUTED 400 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cesamet

Products Affected

- CESAMET

QL Criteria	0.07 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cesia

Products Affected

- CESIA

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

Cetrotide

Products Affected

- CETROTIDE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cevimeline HCl

Products Affected

- *cevimeline hcl*

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

Chantix

Products Affected

- CHANTIX

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

Chantix Continuing Month Pak

Products Affected

- CHANTIX CONTINUING MONTH PAK

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

Chantix Starting Month Pak

Products Affected

- CHANTIX STARTING MONTH PAK

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

Chateal

Products Affected

- CHATEAL

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

Chenodal

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Covered Uses	Cholesterol-type gallstones, Cerebrotendinous Xanthomatosis (CTX)
Exclusion Criteria	Intrahepatic duct calculus, Chronic constipation in patients with cholesterol gallstones, Prophylaxis of recurrent gallstones, Hyperlipidemia, Rheumatoid Arthritis
Required Medical Information	For treatment of cholesterol-type gallstones, documentation of trial and failure of 2 years of generic ursodiol therapy, and documentaion of inability to undergo surgery due to systemic disease or age.
Age Restrictions	18 Years of age or greater
Prescriber Restrictions	
Coverage Duration	1 month, extended approval after 3 months based on response and laboratory values
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Choice DM Fora G20 Test Strips

Products Affected

- CHOICE DM FORA G20 TEST STRIPS

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cialis

Products Affected

- CIALIS ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	Benign Prostatic hyperplasia (BPH)
Exclusion Criteria	Use solely for erectile dysfunction.
Required Medical Information	Diagnosis of benign prostatic hyperplasia, a trial and failure of two alpha blockers, and trial and failure of one 5-alpha reductase inhibitor
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	6 TABS Per 1 Month
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cialis

Products Affected

- CIALIS ORAL TABLET 20 MG, 10 MG

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

Cimzia

Products Affected

- CIMZIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.04 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cimzia Prefilled

Products Affected

- CIMZIA PREFILLED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.04 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cimzia Starter Kit

Products Affected

- CIMZIA STARTER KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.11 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciprofloxacin-Ciproflox HCl ER

Products Affected

- *ciprofloxacin-ciproflox hcl er oral tablet extended release 24 hr* 500 mg*

QL Criteria	3 TB24 Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ciprofloxacin-Ciproflox HCl ER

Products Affected

- *ciprofloxacin-ciproflox hcl er oral tablet extended release 24 hr* 1000 mg*

QL Criteria	14 TB24 Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Citalopram Hydrobromide

Products Affected

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

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

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 40 mg*

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

Claravis

Products Affected

- CLARAVIS

ST Criteria	Documented step through MINOCYCLINE OR DOXYCYCLINE
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

Clarithromycin

Products Affected

- *clarithromycin oral suspension reconstituted*

QL Criteria	150 SUSR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarithromycin

Products Affected

- *clarithromycin oral suspension reconstituted*

QL Criteria	150 mL Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clarithromycin ER

Products Affected

- *clarithromycin er*

QL Criteria	28 TB24 Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code

Products Affected

- CLEVER CHEK AUTO-CODE

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

Clever Chek Auto-Code Test

Products Affected

- CLEVER CHEK AUTO-CODE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code Voice

Products Affected

- CLEVER CHEK AUTO-CODE VOICE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Test

Products Affected

- CLEVER CHEK TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Choice Auto-Code Test

Products Affected

- CLEVER CHOICE AUTO-CODE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Choice Micro Test

Products Affected

- CLEVER CHOICE MICRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Climara Pro

Products Affected

- CLIMARA PRO

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

Clindamycin Phos-Benzoyl Perox

Products Affected

- *clindamycin phos-benzoyl perox external 1-5 %*

QL Criteria	1.67 GEL Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ClomiPHENE Citrate

Products Affected

- *clomiphene citrate oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CloNIDine HCl

Products Affected

- *clonidine hcl transdermal*

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

CloNIDine HCl ER

Products Affected

- *clonidine hcl er*

ST Criteria	Documented step through a STIMULANT
QL Criteria	4 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate*

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

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate*

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

CloZAPine

Products Affected

- *clozapine oral tablet 50 mg, 25 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 100 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet 100 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 200 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 25 mg*

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

Coartem

Products Affected

- COARTEM

PA Criteria	Criteria Details
Covered Uses	Malaria
Exclusion Criteria	Prevention of malaria
Required Medical Information	Diagnosis of malaria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 days
Other Criteria	
QL Criteria	24 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Colchicine

Products Affected

- *colchicine oral tablet*

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

Colcrys

Products Affected

- COLCRYS

PA Criteria	Criteria Details
Covered Uses	Acute gout flares, Familial Mediterranean Fever, Gout prevention
Exclusion Criteria	
Required Medical Information	For gout prevention, the patient has had at least two acute gout attacks in one year, presence of tophi, or radiographic joint damage, and planned initiation of urate-lowering pharmacotherapy such as allopurinol or Uloric (Uloric requires a step through allopurinol)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE GOUT FLARES - 5 days. FAMILIAL MEDITERRANEAN FEVER - 3 years. GOUT PREVENTION - 6 months.
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Colyte with Flavor Packs

Products Affected

- COLYTE WITH FLAVOR PACKS ORAL SOLUTION RECONSTITUTED 227.1 GM

QL Criteria	3785 SOLR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Colyte with Flavor Packs

Products Affected

- COLYTE WITH FLAVOR PACKS ORAL SOLUTION RECONSTITUTED 240 GM

QL Criteria	4000 SOLR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CombiPatch

Products Affected

- COMBIPATCH

QL Criteria	0.34 PATCHES Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Combivent

Products Affected

- COMBIVENT

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

Combivent Respimat

Products Affected

- COMBIVENT RESPIMAT

QL Criteria	0.27 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cometriq (100 mg Daily Dose)

Products Affected

- COMETRIQ (100 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 kits Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cometriq (140 mg Daily Dose)

Products Affected

- COMETRIQ (140 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 kits Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cometriq (60 mg Daily Dose)

Products Affected

- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 kits Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Complera

Products Affected

- COMPLERA

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

Control AST

Products Affected

- CONTROL AST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Control Test

Products Affected

- CONTROL TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cordran

Products Affected

- CORDRAN EXTERNAL TAPE

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

Coreg CR

Products Affected

- COREG CR

ST Criteria	Documented step through CARVEDILOL
QL Criteria	1 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Corifact

Products Affected

- CORIFACT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cosopt PF

Products Affected

- COSOPT PF

ST Criteria	Documented step through DORZOLAMIDE/TIMOLOL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Creon

Products Affected

- CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000 UNIT, 3000-9500 UNIT, 6000 UNIT, 24000 UNIT

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Crestor

Products Affected

- CRESTOR

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Crinone

Products Affected

- CRINONE

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology) Secondary amenorrhea Prevention of early pregnancy failure
Exclusion Criteria	Crinone, Endometrin, First Progesterone VGS is NOT covered for members with the following criteria: A. Use not approved by the FDA: and B. The use is unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining ?accepted use?).
Required Medical Information	Crinone, Endometrin, First Progesterone VGS is covered for members who meet the following criteria: A. ART (Assisted Reproductive Technology): Crinone 8%, Endometrin, First Progesterone VGS a. Documented diagnosis of progesterone deficiency in an infertile woman, AND b. Member must have infertility coverage OR B. Secondary amenorrhea: Crinone 4%, Crinone 8% a. Documented diagnosis of progesterone deficiency in an infertile woman, AND b. Crinone 8% is only for use in women who have failed to respond to treatment with Crinone 4%, AND c. Member must have infertility coverage OR C. Prevention of early pregnancy failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	

Revision Date	Prior Authorization: September 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cryselle-28

Products Affected

- CRYSELLE-28

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

Cuvposa

Products Affected

- CUVPOSA

PA Criteria	Criteria Details
Covered Uses	neurologic conditions associated with drooling (e.g. cerebral palsy)
Exclusion Criteria	
Required Medical Information	Documentaion of neurologic conditions associated with drooling (e.g. cerebral palsy) to reduce severe chronic drooling
Age Restrictions	3 years to 16 years
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CVS Blood Glucose Test

Products Affected

- *cvs blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CVS Nicotine

Products Affected

- *cvs nicotine*

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

CVS NTS Step 1

Products Affected

- *cvs nts step 1*

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

Cyclafem 1/35

Products Affected

- CYCLAFEM 1/35

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

Cyclessa

Products Affected

- CYCLESSA

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

Cycloset

Products Affected

- CYCLOSET

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

Cystagon

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dacogen

Products Affected

- DACOGEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daklinza

Products Affected

- DAKLINZA

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

Daliresp

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	Severe COPD
Exclusion Criteria	Use for relief of acute bronchospasm
Required Medical Information	Diagnosis of severe COPD (FEV1 less than 50% predicted) associated with chronic bronchitis and at least one documented COPD exacerbation in the previous year, and an inadequate response or contraindication to a combination or single agent long-acting beta 2-agonist agent and Spiriva/Tudorza. An inadequate response to standard therapy shall include any exacerbation event requiring intervention with systemic glucocorticosteroids or hospitalization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dasetta 1/35

Products Affected

- DASETTA 1/35

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

Daysee

Products Affected

- DAYSEE

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

Daytrana

Products Affected

- DAYTRANA

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 patch Per 1 DAY
Notes/ References	

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

Delzicol

Products Affected

- DELZICOL

ST Criteria	Documented failure, contraindication, or intolerance to APRISO
QL Criteria	12 CPDR Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Denavir

Products Affected

- DENAVIR

ST Criteria	Documented step through oral Acyclovir
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Depo-Provera

Products Affected

- DEPO-PROVERA INTRAMUSCULAR*
  SUSPENSION 150 MG/ML

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

Depo-SubQ Provera 104

Products Affected

- DEPO-SUBQ PROVERA 104

PA Criteria	Criteria Details
Covered Uses	Contraception/hormone therapy
Exclusion Criteria	
Required Medical Information	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of one preferred oral generic alternative or a documented mental or physical handicap preventing the reasonable use of an oral contraceptive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 SUSP Per 90 DAYs
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desloratadine

Products Affected

- *desloratadine*

ST Criteria	Documented step through TWO of the following: CLARITIN OTC, ZYRTEC OTC, ALLEGRA OTC
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

Desloratadine

Products Affected

- *desloratadine*

ST Criteria	Documented step through TWO of the following: CLARITIN OTC, ZYRTEC OTC, ALLEGRA OTC
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desloratadine

Products Affected

- *desloratadine*

ST Criteria	Documented step through TWO of the following: CLARITIN OTC, ZYRTEC OTC, ALLEGRA OTC
QL Criteria	1 TBDP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Desogen

Products Affected

- DESOGEN

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

Dexilant

Products Affected

- DEXILANT

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	Rabeprazole up to 20 mg/day, Dexilant up to 60 mg/day, and Nexium up to 40 mg/day are available with prior-authorization when the following criteria is met: Step through Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. High Dose Nexium, Rabeprazole and Prevacid solutabs are available with prior-authorization when the following criteria is met: Nexium up to 80mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Rabeprazole up to 40mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Prevacid solutabs up to 60mg/day for members greater than 1 year old with documentation of: inability to swallow tablets/capsules and step through ONE of the following: 80mg/day of omeprazole (capsules may be opened and sprinkled on 1 tablespoon of applesauce), or 60mg/day of Prevacid 24H OTC (capsule may be opened and sprinkled on 1 tablespoon of applesauce, Ensure pudding, cottage cheese, yogurt, or strained pears, or emptied into 60mL of apple juice, orange juice, or tomato juice)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short Term course of high dose PPI 3-6 months. Long term course up to 1 Year.

PA Criteria	Criteria Details
Other Criteria	A step through one of these high dose therapies (80mg/day of Prilosec OTC/omeprazole or pantoprazole, OR 60mg/day of Prevacid 24H OTC) is required even if the member was previously approved for Rabeprazole, Prevacid solutabs, or Nexium at standard dosing. Exceptions may be considered if there is documentation of intolerance, e.g., side-effects or allergies to Prilosec OTC/omeprazole, pantoprazole, and Prevacid 24H OTC.
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 cap Per 1 Day
Notes/ References	

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 CP24 Per 1 DAY
Notes/ References	

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/ References	

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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

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

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

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

Diazepam

Products Affected

- *diazepam*

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

Diazepam

Products Affected

- *diazepam*

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

Diethylpropion HCl

Products Affected

- *diethylpropion hcl oral*

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Diethylpropion HCl ER

Products Affected

- *diethylpropion hcl er*

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Differin

Products Affected

- DIFFERIN EXTERNAL 0.3 %
- DIFFERIN EXTERNAL LOTION

ST Criteria	Documented step through TRETINOIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dificid

Products Affected

- DIFICID

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Initial episodes of mild, moderate, or severe CDI. Severe complicated CDI (i.e. hypotension, ileus, megacolon, or shock).
Required Medical Information	Step through two courses of antibiotics: metronidazole and/or oral vancomycin
Age Restrictions	
Prescriber Restrictions	18 years old or greater
Coverage Duration	10 Days of therapy
Other Criteria	
QL Criteria	20 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dihydroergotamine Mesylate

Products Affected

- *dihydroergotamine mesylate injection*

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

Dilt-CD

Products Affected

- *dilt-cd oral capsule extended release 24 hour 300 mg, 120 mg, 180 mg*

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

Dilt-CD

Products Affected

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

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diltiazem HCl CD

Products Affected

- *diltiazem hcl cd*

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

Diltiazem HCl ER

Products Affected

- *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg*
- *diltiazem hcl er oral capsule extended release 12 hour 120 mg*

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

Diltiazem HCl ER

Products Affected

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

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diltiazem HCl ER Beads

Products Affected

- *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 360 mg, 180 mg, 420 mg, 300 mg*

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

Diltiazem HCl ER Beads

Products Affected

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

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Diltiazem HCl ER Coated Beads

Products Affected

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

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

Diltiazem HCl ER Coated Beads

Products Affected

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

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dilt-XR

Products Affected

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

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dilt-XR

Products Affected

- *dilt-xr oral capsule extended release 24 hour*
  120 mg, 180 mg

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

Diltzac

Products Affected

- *diltzac oral capsule extended release 24 hour 120 mg, 300 mg, 360 mg, 180 mg*

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

Diltzac

Products Affected

- *diltzac oral capsule extended release 24 hour 240 mg*

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dipentum

Products Affected

- DIPENTUM

ST Criteria	Documented failure, contraindication or intolerance to Apriso AND Balsalazide
QL Criteria	4 CAPS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Donepezil HCl

Products Affected

- *donepezil hcl oral tablet*

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

Donepezil HCl

Products Affected

- *donepezil hcl oral tablet*

ST Criteria	Documented step through DONEPEZIL 10MG
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

Dronabinol

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	Anorexia associated with weight loss in patients with AIDS, Chemotherapy-induced nausea and vomiting
Exclusion Criteria	Multiple sclerosis (spasticity), Fibromyalgia (Neuropathic Pain)
Required Medical Information	A diagnosis of anorexia associated with weight loss in patients with AIDS or for the treatment of chemotherapy induced nausea and vomiting who have failed to respond to conventional antiemetic therapies (such as prochlorperazine, chlorpromazine, haloperidol and metoclopramide)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 12 months if demonstrated adequate response to therapy.
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dulera

Products Affected

- DULERA

QL Criteria	0.44 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

DULoxetine HCl

Products Affected

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

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

DULoxetine HCl

Products Affected

- *duloxetine hcl oral capsule delayed release particles 30 mg, 60 mg*

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

DULoxetine HCl

Products Affected

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

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

Dutasteride

Products Affected

- *dutasteride*

ST Criteria	Documented step through FINASTERIDE
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

Easy Plus II Glucose Test

Products Affected

- *easy plus ii glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Step Test

Products Affected

- EASY STEP TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Talk Blood Glucose Test

Products Affected

- *easy talk blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Touch Test

Products Affected

- EASY TOUCH TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Trak Blood Glucose Test

Products Affected

- *easy trak blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyGluco

Products Affected

- EASYGLUCO IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyMax 15 Test

Products Affected

- EASYMAX 15 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EASYMax Test

Products Affected

- EASYMAX TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyPlus Blood Glucose Test

Products Affected

- *easyplus blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyPRO Plus

Products Affected

- EASYPRO PLUS IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eclipse Test

Products Affected

- ECLIPSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Edarbi

Products Affected

- EDARBI

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

Edarbyclor

Products Affected

- EDARBYCLOR

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

Edex

Products Affected

- EDEX

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

Edurant

Products Affected

- EDURANT

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

Effient

Products Affected

- EFFIENT

ST Criteria	Documented step through CLOPIDOGREL
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Egrifta

Products Affected

- EGRIFTA

PA Criteria	Criteria Details
Covered Uses	lipodystrophy due to antiretroviral medications
Exclusion Criteria	Disruption of the hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation or head trauma. Active malignancy (either newly diagnosed or recurrent). Known hypersensitivity to tesamorelin or mannitol (an excipient). Body Mass Index (BMI) less than 20 kg/m3. Use for weight loss management.
Required Medical Information	Patient is being treated with antiretroviral therapy, is compliant with antiretroviral therapy with an adherence rate of greater than 80%, and documentation of lipodystrophy due to antiretroviral medications is provided. Parameters are as follows for men: waist circumference greater than or = 95 cm (37.4 inches) and waist-to-hip ratio greater than or = 0.94. Parameters are as follows for women: waist circumference greater than or = 94 cm (37.0 inches) and waist-to-hip ratio greater than or = 0.88.
Age Restrictions	
Prescriber Restrictions	Provider who specializes in the treatment of HIV
Coverage Duration	Initial Approval: 6 months
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elaprase

Products Affected

- ELAPRASE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elelyso

Products Affected

- ELELYSO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Element Plus Test

Products Affected

- ELEMENT PLUS TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Element Test

Products Affected

- ELEMENT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elidel

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Children less than 2 years of age. Children and adults with weakened immune systems. Documentation of hypersensitivity to pimecrolimus, tacrolimus or any component in the product. Those with Netherton?s syndrome.
Required Medical Information	A. Adults: trial and failure of at least one formulary topical corticosteroid of medium to high, OR B. Children (? 2 years of age): trial and failure of at least one formulary low potency topical corticosteroid, OR C. Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas, OR D. Documentation of a contraindication to topical corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3.34 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elinest

Products Affected

- ELINEST

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

Eliquis

Products Affected

- ELIQUIS

ST Criteria	Documented step through WARFARIN
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ella

Products Affected

- ELLA

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

Eloctate

Products Affected

- ELOCTATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Embeda

Products Affected

- EMBEDA

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Embrace Blood Glucose Test

Products Affected

- EMBRACE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emend

Products Affected

- EMEND ORAL CAPSULE 80 & 125 MG

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

Emend

Products Affected

- EMEND ORAL CAPSULE 80 MG, 40 MG

QL Criteria	1.67 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emend

Products Affected

- EMEND ORAL CAPSULE 125 MG

QL Criteria	1.67 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emoquette

Products Affected

- EMOQUETTE

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

Emsam

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	Major Dispressive Disorder (MDD)
Exclusion Criteria	Patients taking products containing venlafaxine concomitantly, patients taking MAOIs concomitantly, for use in pediatrics.
Required Medical Information	Patient has documented failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses, or patient is a new member and has been receiving Emsam therapy for more than 4 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Examples of antidepressant trials from unique Therapeutic Subclass include SSRIs, SNRIs, NDRIs, TCAs, tetracyclic antidepressants, and MAOIs
QL Criteria	1 patch Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emtriva

Products Affected

- EMTRIVA ORAL CAPSULE

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

Enablex

Products Affected

- ENABLEX

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

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.29 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Endometrin

Products Affected

- ENDOMETRIN

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology) Secondary amenorrhea Prevention of early pregnancy failure
Exclusion Criteria	Crinone, Endometrin, First Progesterone VGS is NOT covered for members with the following criteria: A. Use not approved by the FDA: and B. The use is unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining ?accepted use?).
Required Medical Information	Crinone, Endometrin, First Progesterone VGS is covered for members who meet the following criteria: A. ART (Assisted Reproductive Technology): Crinone 8%, Endometrin, First Progesterone VGS a. Documented diagnosis of progesterone deficiency in an infertile woman, AND b. Member must have infertility coverage OR B. Secondary amenorrhea: Crinone 4%, Crinone 8% a. Documented diagnosis of progesterone deficiency in an infertile woman, AND b. Crinone 8% is only for use in women who have failed to respond to treatment with Crinone 4%, AND c. Member must have infertility coverage OR C. Prevention of early pregnancy failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	

Revision Date	Prior Authorization: September 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enjuvia

Products Affected

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

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

Enjuvia

Products Affected

- ENJUVIA ORAL TABLET 1.25 MG

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

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium injection*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thrombopropylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.
QL Criteria	6 SOLN Per 1 DAY

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

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

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium subcutaneous* solution 40 mg/0.4ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

QL Criteria	0.8 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium subcutaneous* solution 100 mg/ml, 150 mg/ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

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

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium subcutaneous* solution 80 mg/0.8ml, 120 mg/0.8ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thrombopropylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

QL Criteria	1.6 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium subcutaneous* solution 60 mg/0.6ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

QL Criteria	1.2 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium subcutaneous* solution 30 mg/0.3ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

QL Criteria	0.6 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enpresse-28

Products Affected

- ENPRESSE-28

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

Entecavir

Products Affected

- *entecavir*

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

Entecavir

Products Affected

- *entecavir*

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

Envision Autocode Test

Products Affected

- ENVISION AUTOCODE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Epiduo

Products Affected

- EPIDUO

ST Criteria	Documented step through TRETINOIN
QL Criteria	1.5 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Epiduo Forte

Products Affected

- EPIDUO FORTE

ST Criteria	Documented step through TRETINOIN
QL Criteria	1.5 grams Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EPINEPHrine

Products Affected

- *epinephrine injection*

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

Eplerenone

Products Affected

- *eplerenone oral tablet 25 mg*

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

Eplerenone

Products Affected

- *eplerenone oral tablet 50 mg*

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

Epogen

Products Affected

- EPOGEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Epoprostenol Sodium

Products Affected

- *epoprostenol sodium*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

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

EQ Nicotine

Products Affected

- *eq nicotine transdermal patch 24 hr 14 mg/24hr, 21 mg/24hr*

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

EQL Nicotine

Products Affected

- *eql nicotine*

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

Erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Errin

Products Affected

- ERRIN

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

Escitalopram Oxalate

Products Affected

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

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

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

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	Rabeprazole up to 20 mg/day, Dexilant up to 60 mg/day, and Nexium up to 40 mg/day are available with prior-authorization when the following criteria is met: Step through Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. High Dose Nexium, Rabeprazole and Prevacid solutabs are available with prior-authorization when the following criteria is met: Nexium up to 80mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Rabeprazole up to 40mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Prevacid solutabs up to 60mg/day for members greater than 1 year old with documentation of: inability to swallow tablets/capsules and step through ONE of the following: 80mg/day of omeprazole (capsules may be opened and sprinkled on 1 tablespoon of applesauce), or 60mg/day of Prevacid 24H OTC (capsule may be opened and sprinkled on 1 tablespoon of applesauce, Ensure pudding, cottage cheese, yogurt, or strained pears, or emptied into 60mL of apple juice, orange juice, or tomato juice)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short Term course of high dose PPI 3-6 months. Long term course up to 1 Year.

PA Criteria	Criteria Details
Other Criteria	A step through one of these high dose therapies (80mg/day of Prilosec OTC/omeprazole or pantoprazole, OR 60mg/day of Prevacid 24H OTC) is required even if the member was previously approved for Rabeprazole, Prevacid solutabs, or Nexium at standard dosing. Exceptions may be considered if there is documentation of intolerance, e.g., side-effects or allergies to Prilosec OTC/omeprazole, pantoprazole, and Prevacid 24H OTC.
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estradiol

Products Affected

- *estradiol transdermal patch weekly*

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

Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

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

Estrasorb

Products Affected

- ESTRASORB

QL Criteria	3.48 EMUL Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estrogel

Products Affected

- ESTROGEL

QL Criteria	1.67 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estrostep Fe

Products Affected

- ESTROSTEP FE

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

Eszopiclone

Products Affected

- *eszopiclone*

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

Evamist

Products Affected

- EVAMIST

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

EvenCare + Blood Glucose Test

Products Affected

- EVENCARE + BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare Blood Glucose Test

Products Affected

- EVENCARE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare G2 Test

Products Affected

- EVENCARE G2 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare G3 Test

Products Affected

- EVENCARE G3 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Evolution Autocode

Products Affected

- EVOLUTION AUTOCODE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exalgo

Products Affected

- EXALGO ORAL 32 MG

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exforge

Products Affected

- EXFORGE

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

Exforge HCT

Products Affected

- EXFORGE HCT

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

Exforge HCT

Products Affected

- EXFORGE HCT

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

Exjade

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Extavia

Products Affected

- EXTAVIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	tests or symptoms of jaundice
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.5 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Blood Glucose Test

Products Affected

- EZ SMART BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Plus Glucose Test

Products Affected

- EZ SMART PLUS GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fabrazyme

Products Affected

- FABRAZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Factive

Products Affected

- FACTIVE

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

Falmina

Products Affected

- FALMINA

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

Famciclovir

Products Affected

- *famciclovir oral tablet 500 mg*

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

Famciclovir

Products Affected

- *famciclovir oral tablet 250 mg, 125 mg*

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

Fanapt

Products Affected

- FANAPT

ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fanapt Titration Pack

Products Affected

- FANAPT TITRATION PACK

ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FastTake Test

Products Affected

- FASTTAKE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
  200 MG

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

FazaClo

Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE
  150 MG

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

Felodipine ER

Products Affected

- *felodipine er*

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

Femcon Fe

Products Affected

- FEMCON FE

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

Femhrt Low Dose

Products Affected

- FEMHRT LOW DOSE

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

Femring

Products Affected

- FEMRING

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

Fenofibric Acid

Products Affected

- *fenofibric acid oral tablet*

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

Fenoglide

Products Affected

- FENOGLIDE ORAL TABLET 120 MG

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

FentaNYL

Products Affected

- *fentanyl*

QL Criteria	20 patches Per 30 DAYs
Notes/ References	
Revision Date	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
Covered Uses	Pain due to malignant diagnosis only
Exclusion Criteria	Non-malignant pain, management of acute or postoperative or in patients not taking chronic opiates or not tolerant to opioid therapy.
Required Medical Information	Fentanyl citrate is covered for members with pain due to malignant diagnosis only, and who are already receiving and are tolerant to opioid therapy and who are intolerant of two (2) other immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone. (Patients who are considered opioid tolerant are those who are taking at least 60 mg morphine/day, 25 mcg transdermal fentanyl/hour, or an equianalgesic dose of another opioid for at least a week).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	4 loz Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ferriprox

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Antidotes.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fifty50 Glucose Test 2.0

Products Affected

- FIFTY50 GLUCOSE TEST 2.0

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Firazyr

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/hereditary_angioedema.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 syr Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

First-Progesterone VGS 100

Products Affected

- FIRST-PROGESTERONE VGS 100

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Crinone, Endometrin, First Progesterone VGS is NOT covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Crinone, Endometrin, First Progesterone VGS are covered for members who meet the following criteria: (1) ART (Assisted Reproductive Technology): Crinone 8%, Endometrin, First Progesterone VGS: Documented diagnosis of progesterone deficiency in an infertile woman and member must have infertility coverage, or (2) Secondary amenorrhea: Crinone 4%, Crinone 8%: Documented diagnosis of progesterone deficiency in an infertile woman, and Crinone 8% is only for use in women who have failed to respond to treatment with Crinone 4%, and member must have infertility coverage, or (3) Prevention of early pregnancy failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

First-Progesterone VGS 200

Products Affected

- FIRST-PROGESTERONE VGS 200

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Crinone, Endometrin, First Progesterone VGS is NOT covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Crinone, Endometrin, First Progesterone VGS are covered for members who meet the following criteria: (1) ART (Assisted Reproductive Technology): Crinone 8%, Endometrin, First Progesterone VGS: Documented diagnosis of progesterone deficiency in an infertile woman and member must have infertility coverage, or (2) Secondary amenorrhea: Crinone 4%, Crinone 8%: Documented diagnosis of progesterone deficiency in an infertile woman, and Crinone 8% is only for use in women who have failed to respond to treatment with Crinone 4%, and member must have infertility coverage, or (3) Prevention of early pregnancy failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

First-Progesterone VGS 25

Products Affected

- FIRST-PROGESTERONE VGS 25

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Crinone, Endometrin, First Progesterone VGS is NOT covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Crinone, Endometrin, First Progesterone VGS are covered for members who meet the following criteria: (1) ART (Assisted Reproductive Technology): Crinone 8%, Endometrin, First Progesterone VGS: Documented diagnosis of progesterone deficiency in an infertile woman and member must have infertility coverage, or (2) Secondary amenorrhea: Crinone 4%, Crinone 8%: Documented diagnosis of progesterone deficiency in an infertile woman, and Crinone 8% is only for use in women who have failed to respond to treatment with Crinone 4%, and member must have infertility coverage, or (3) Prevention of early pregnancy failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

First-Progesterone VGS 400

Products Affected

- FIRST-PROGESTERONE VGS 400

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Crinone, Endometrin, First Progesterone VGS is NOT covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Crinone, Endometrin, First Progesterone VGS are covered for members who meet the following criteria: (1) ART (Assisted Reproductive Technology): Crinone 8%, Endometrin, First Progesterone VGS: Documented diagnosis of progesterone deficiency in an infertile woman and member must have infertility coverage, or (2) Secondary amenorrhea: Crinone 4%, Crinone 8%: Documented diagnosis of progesterone deficiency in an infertile woman, and Crinone 8% is only for use in women who have failed to respond to treatment with Crinone 4%, and member must have infertility coverage, or (3) Prevention of early pregnancy failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

First-Progesterone VGS 50

Products Affected

- FIRST-PROGESTERONE VGS 50

PA Criteria	Criteria Details
Covered Uses	ART (Assisted Reproductive Technology), secondary amenorrhea, prevention of early pregnancy failure
Exclusion Criteria	Crinone, Endometrin, First Progesterone VGS is NOT covered for uses not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Crinone, Endometrin, First Progesterone VGS are covered for members who meet the following criteria: (1) ART (Assisted Reproductive Technology): Crinone 8%, Endometrin, First Progesterone VGS: Documented diagnosis of progesterone deficiency in an infertile woman and member must have infertility coverage, or (2) Secondary amenorrhea: Crinone 4%, Crinone 8%: Documented diagnosis of progesterone deficiency in an infertile woman, and Crinone 8% is only for use in women who have failed to respond to treatment with Crinone 4%, and member must have infertility coverage, or (3) Prevention of early pregnancy failure
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flebogamma DIF

Products Affected

- FLEBOGAMMA DIF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flovent Diskus

Products Affected

- FLOVENT DISKUS

ST Criteria	Documented step through QVAR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flovent HFA

Products Affected

- FLOVENT HFA

ST Criteria	Documented step through QVAR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flunisolide

Products Affected

- *flunisolide nasal solution 29 mcg/act (0.025%)*

QL Criteria	1.67 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Flunisolide

Products Affected

- *flunisolide nasal solution 25 mcg/act (0.025%)*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 40 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

QL Criteria	0.14 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fluticasone Propionate

Products Affected

- *fluticasone propionate nasal*

QL Criteria	1.07 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	2 CAPS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fluvastatin Sodium ER

Products Affected

- *fluvastatin sodium er*

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FluvoxaMINE Maleate

Products Affected

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

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

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

Focalin XR

Products Affected

- FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG, 25 MG, 35 MG, 20 MG, 10 MG, 40 MG

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	

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

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium subcutaneous* solution*
  10 mg/0.8ml

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

QL Criteria	0.8 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium subcutaneous* solution 5 mg/0.4ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

QL Criteria	0.4 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium subcutaneous* solution 2.5 mg/0.5ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

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QL Criteria	0.5 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium subcutaneous* solution 7.5 mg/0.6ml*

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thromboprophylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.

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(Updated 12/01/2015)

QL Criteria	0.6 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA D10 2-in-1 Monitor

Products Affected

- FORA D10 2-IN-1 MONITOR

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

FORA D10 Blood Glucose Test

Products Affected

- FORA D10 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA D15C Blood Glucose Test

Products Affected

- FORA D15C BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA D15g 2-in-1 Monitor

Products Affected

- FORA D15G 2-IN-1 MONITOR

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

FORA D15g Blood Glucose Test

Products Affected

- FORA D15G BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA D15z Blood Glucose Test

Products Affected

- FORA D15Z BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA D20 2-in-1 Monitor

Products Affected

- FORA D20 2-IN-1 MONITOR

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

FORA D20 Blood Glucose Test

Products Affected

- FORA D20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G20 Blood Glucose Test

Products Affected

- FORA G20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G30a Blood Glucose Test

Products Affected

- FORA G30A BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G71a Blood Glucose Test

Products Affected

- FORA G71A BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G90 Blood Glucose Test

Products Affected

- FORA G90 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fora GD20 Test

Products Affected

- FORA GD20 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V10 Blood Glucose Test

Products Affected

- FORA V10 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V12 Blood Glucose Test

Products Affected

- FORA V12 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V20 Blood Glucose Test

Products Affected

- FORA V20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V22 Blood Glucose Test

Products Affected

- FORA V22 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V30a Blood Glucose Test

Products Affected

- FORA V30A BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ForaCare GD40 Test

Products Affected

- FORACARE GD40 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ForaCare premium V10 Test

Products Affected

- FORACARE PREMIUM V10 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Foradil Aerolizer

Products Affected

- FORADIL AEROLIZER

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

Forteo

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fortesta

Products Affected

- FORTESTA

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	4 GM Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fortical

Products Affected

- FORTICAL

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.13 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fosamax Plus D

Products Affected

- FOSAMAX PLUS D

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.15 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fragmin

Products Affected

- FRAGMIN

PA Criteria	Criteria Details
Covered Uses	Perioperative management Prevention of VTE Orthopedic procedures Treatment of VTE, PE, Superficial thrombophlebitis Pregnancy: Treatment of VTE, Prevention of VTE, At risk Acute ST-elevated MI Cancer Long distance travel Heparin Induced Thrombocytopenia
Exclusion Criteria	LMWH therapy is considered to be contraindicated, therefore, not covered for patients with strongly suspected heparin-induced thrombocytopenia, whether or not complicated by thrombosis. Heparin therapy may be preferred over low molecular weight heparin therapy in patients with severe renal insufficiency. Routine use of thrombopropylaxis in isolated lower-extremity injuries distal to the knee is not recommended. The routine VTE prophylaxis of cancer patients using LMWH, UFH or fondiparinux is not covered unless criteria of another section of this policy are met. CHEST guidelines recommend against cancer patients who are fully ambulatory routinely be given thromboprophylaxis. The results of additional trials are required before any recommendations can be made about the use of anticoagulants in cancer patients who do not have a traditional indication for thromboprophylaxis, or as a method to improve survival.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Use of dalteparin, fondaparinux, and Innohep will require trial and failure of enoxaparin first. Member may receive a total of up to 21 days of initial therapy with enoxaparin without a prior authorization.
QL Criteria	1 syringe Per 1 DAY

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

FreeStyle InsuLinx Test

Products Affected

- FREESTYLE INSULINX TEST

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

FreeStyle Lite Test

Products Affected

- FREESTYLE LITE TEST

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

FreeStyle Test

Products Affected

- FREESTYLE TEST

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

Frova

Products Affected

- FROVA

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	0.3 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fulyzaq

Products Affected

- FULYZAQ

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

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gabapentin

Products Affected

- *gabapentin oral tablet*

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

Galantamine Hydrobromide ER

Products Affected

- *galantamine hydrobromide er*

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

Gammagard

Products Affected

- GAMMAGARD

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gammaked

Products Affected

- GAMMAKED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gammaplex

Products Affected

- GAMMAPLEX INTRAVENOUS*
  SOLUTION 2.5 GM/50ML, 5 GM/100ML, 10 GM/200ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gamunex-C

Products Affected

- GAMUNEX-C

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gattex

Products Affected

- GATTEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Gattex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.04 KIT Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GaviLyte-C

Products Affected

- GAVILYTE-C

QL Criteria	4000 SOLR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GaviLyte-G

Products Affected

- GAVILYTE-G

QL Criteria	4000 SOLR Per 1 FILL
Notes/ References	
Revision Date	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*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gelnique

Products Affected

- GELNIQUE TRANSDERMAL 10 %

ST Criteria	Documented step through OXYBUTYNIN or TROSPIUM AND VESICARE or MYRBETRIQ
QL Criteria	1 sachet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gelnique

Products Affected

- GELNIQUE TRANSDERMAL 3 (28) % (MG/ACT)

ST Criteria	Documented step through OXYBUTYNIN or TROSPIUM AND VESICARE or MYRBETRIQ
QL Criteria	3.1 GM Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Generess FE

Products Affected

- GENERESS FE

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

Gianvi

Products Affected

- GIANVI

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

Giazo

Products Affected

- GIAZO

ST Criteria	Documented step through BALSALAZIDE
QL Criteria	6 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gildagia

Products Affected

- GILDAGIA

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

Gildess 1.5/30

Products Affected

- GILDESS 1.5/30

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

Gildess 1/20

Products Affected

- GILDESS 1/20

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

Gildess FE 1.5/30

Products Affected

- GILDESS FE 1.5/30

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

Gildess FE 1/20

Products Affected

- GILDESS FE 1/20

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

Gilenya

Products Affected

- GILENYA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gilotrif

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gleevec

Products Affected

- GLEEVEC

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GlucaGen HypoKit

Products Affected

- GLUCAGEN HYPOKIT

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

Glucagon Emergency

Products Affected

- GLUCAGON EMERGENCY

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

Glucocard 01 Sensor Plus

Products Affected

- GLUCOCARD 01 SENSOR PLUS

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glucocard Expression Test

Products Affected

- GLUCOCARD EXPRESSION TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glucocard Shine Test

Products Affected

- GLUCOCARD SHINE TEST

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

Glucocard Vital Test

Products Affected

- GLUCOCARD VITAL TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glucocard X-Sensor

Products Affected

- GLUCOCARD X-SENSOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GlucoCom Test

Products Affected

- GLUCOCOM TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GlucoLab Test

Products Affected

- GLUCOLAB TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glumetza

Products Affected

- GLUMETZA

ST Criteria	Documented step through METFORMIN 1500MG/day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise

Products Affected

- GRALISE ORAL TABLET 300 MG

ST Criteria	Documented step through GABAPENTIN
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise

Products Affected

- GRALISE ORAL TABLET 600 MG

ST Criteria	Documented step through GABAPENTIN
QL Criteria	3 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise Starter

Products Affected

- GRALISE STARTER

ST Criteria	Documented step through GABAPENTIN
QL Criteria	2.6 MISC Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Granisetron HCl

Products Affected

- *granisetron hcl oral*

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

GuanFACINE HCl ER

Products Affected

- *guanfacine hcl er*

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

Gynazole-1

Products Affected

- GYNAZOLE-1

QL Criteria	5.8 CREA Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Halaven

Products Affected

- HALAVEN

PA Criteria	Criteria Details
Covered Uses	Metastatic breast cancer
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR
Other Criteria	A documented Diagnosis of metastatic breast cancer AND documented prior therapy with both an anthracycline (ex. daunorubicin,bleomycin), and a taxane(ex.Paclitaxel, docetaxel)
Notes/ References	
Revision Date	Prior Authorization: September 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HalfLytely with Flavor Packs

Products Affected

- HALFLYTELY WITH FLAVOR PACKS

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

Helixate FS

Products Affected

- HELIXATE FS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hemofil M

Products Affected

- HEMOFIL M

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hizentra

Products Affected

- HIZENTRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HM Nicotine

Products Affected

- *hm nicotine*

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

Humate-P

Products Affected

- HUMATE-P

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira

Products Affected

- HUMIRA SUBCUTANEOUS* 10 MG/0.2ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira Pediatric Crohns Start

Products Affected

- HUMIRA PEDIATRIC CROHNS START

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hycamtin

Products Affected

- HYCAMTIN ORAL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hydrocod Polst-CPM Polst ER

Products Affected

- *hydrocod polst-cpm polst er*

QL Criteria	120 LQCR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

HYDROmorphone HCl ER

Products Affected

- *hydromorphone hcl er*

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

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.04 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 15 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 45 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ilaris

Products Affected

- ILARIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunomodulators_CAP.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imiquimod

Products Affected

- *imiquimod external*

QL Criteria	48 packet Per 112 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Implanon

Products Affected

- IMPLANON

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

Increlex

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Increlex.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Infergen

Products Affected

- INFERGEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Infinity Blood Glucose Test

Products Affected

- INFINITY BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Inlyta

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Intelence

Products Affected

- INTELENCE ORAL TABLET 25 MG, 100 MG

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

Intelence

Products Affected

- INTELENCE ORAL TABLET 200 MG

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

Intron A

Products Affected

- INTRON A INJECTION SOLUTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Introvale

Products Affected

- INTROVALE

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

Intuniv

Products Affected

- INTUNIV

ST Criteria	Documented step through a STIMULANT
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Invokana

Products Affected

- INVOKANA

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ipratropium Bromide

Products Affected

- *ipratropium bromide nasal solution 0.03 %*

QL Criteria	1.08 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ipratropium Bromide

Products Affected

- *ipratropium bromide nasal solution 0.06 %*

QL Criteria	0.54 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Irbesartan

Products Affected

- *irbesartan*

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

Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide*

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET CHEWABLE

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET

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

Istodax

Products Affected

- ISTODAX

PA Criteria	Criteria Details
Covered Uses	Cutaneous T-cell lymphoma
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

Itraconazole

Products Affected

- *itraconazole oral*

PA Criteria	Criteria Details
Covered Uses	Onychomycosis, invasive fungal infection, uther fungal infection, superficial mycoses
Exclusion Criteria	Cosmetic use, patients with evidence of ventricular dysfunction such as CHF or a history of CHF. Coadministration with certain drugs metabolized by the cytochrome P-450 3A4 isoenzyme system (CYP3A4), cisapride, oral midazolam, pimozide, quinidine, dofetilide, triazolam, HMG-CoA reductase inhibitors metabolized by CYP3A4, such as lovastatin and simvastatin, and ergot alkaloids metabolized by CYP3A4, such as dihydroergotamine, ergotamine, ergonovine, and methylergonovine.
Required Medical Information	Itraconazole Capsules are covered for members who meet the following criteria: (1) Invasive fungal infections in patients who are immunocompromised, such as histoplamosis, aspergillosis, and blastomycosis, (2) Treatment of tinea barbae, tinea capitis, tinea favosa with previous treatment with terbinafine, (3) Treatment of tinea corporis, tinea cruris, tinea faciei, tinea manuum, tinea pedis with previous treatment with a topical antifungal and terbinafine, (4) Treatment of tinea versicolor with previous treatment with selenium sulfide and a topcial antifungal, (5) a diagnosis of majocchi granuloma, (6) Onychomycosis in diabetic patients or patients with peripheral vascular disease and either a positive onychomycosis susceptible pathogen culture or a positive PAS stain performed by a laboratory and documented trial/failure of terbinafine (generic Lamisil), or (7) Onychomycosis with documented disabling pain or impairment and a positive onychomycosis susceptible pathogen culture and documented step through terbinafine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Nail: 12 wk(toe),5 wk (finger) per year,Invasive: 1-3 mo based on severity, Other Dx: 1-6 wk
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	

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Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet

Products Affected

- JANUMET

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet XR

Products Affected

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

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	1 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet XR

Products Affected

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

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	2 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Januvia

Products Affected

- JANUVIA

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jentadueto

Products Affected

- JENTADUETO

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jevantique

Products Affected

- JEVANTIQUE

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

Jinteli

Products Affected

- JINTELI

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

Jolessa

Products Affected

- JOLESSA

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

Junel 1.5/30

Products Affected

- JUNEL 1.5/30

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

Junel 1/20

Products Affected

- JUNEL 1/20

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

Junel FE 1.5/30

Products Affected

- JUNEL FE 1.5/30

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

Junel FE 1/20

Products Affected

- JUNEL FE 1/20

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

Juvisync

Products Affected

- JUVISYNC

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Antilipidemic%20Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 20 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/Antilipidemic%20Agents_HOFH.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Juxtapid

Products Affected

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

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

Kadian

Products Affected

- KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 70 MG, 130 MG, 200 MG, 40 MG, 150 MG

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kadian

Products Affected

- KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 caps Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kalydeco

Products Affected

- KALYDECO

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

Kalydeco

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kapvay

Products Affected

- KAPVAY ORAL

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

Kariva

Products Affected

- KARIVA

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

Kazano

Products Affected

- KAZANO

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kelnor 1/35

Products Affected

- KELNOR 1/35

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

Kepivance

Products Affected

- KEPIVANCE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ketoconazole

Products Affected

- *ketoconazole oral*

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

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

QL Criteria	20 tabs Per 28 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine ophthalmic*

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

Koate-DVI

Products Affected

- KOATE-DVI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kogenate FS

Products Affected

- KOGENATE FS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kogenate FS Bio-Set

Products Affected

- KOGENATE FS BIO-SET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kombiglyze XR

Products Affected

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

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	1 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kombiglyze XR

Products Affected

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

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	2 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Korlym

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/antidiabetic%20agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kroger Blood Glucose Test

Products Affected

- *kroger blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kroger Premium Glucose Test

Products Affected

- *kroger premium glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kroger Test

Products Affected

- *kroger test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kurvelo

Products Affected

- KURVELO

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

Kuvan

Products Affected

- KUVAN ORAL TABLET SOLUBLE

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 25 MG

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

LaMICtal ODT

Products Affected

- LAMICTAL ODT ORAL TABLET DISPERSIBLE 50 MG

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

LamISIL

Products Affected

- LAMISIL ORAL PACKET 187.5 MG

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

LamISIL

Products Affected

- LAMISIL ORAL PACKET 125 MG

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of epilepsy or Bipolar I disorder (Bipolar I disorder ONLY in the case of Lamictal ODT)
Exclusion Criteria	
Required Medical Information	The member has a documented diagnosis of epilepsy or Bipolar I disorder (Bipolar I disorder ONLY in the case of Lamictal ODT) and either documentation of unsatisfactory effects with, intolerability to, or inability to take immediate-release lamotrigine, or in the case of Lamotrigine ER, the member is new to the health plan and has been established on therapy for longer than four weeks with Lamotrigine ER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years for Lamotrigine ER. 1 year for Lamictal ODT.
Other Criteria	
QL Criteria	3 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Diagnosis of epilepsy or Bipolar I disorder (Bipolar I disorder ONLY in the case of Lamictal ODT)
Exclusion Criteria	
Required Medical Information	The member has a documented diagnosis of epilepsy or Bipolar I disorder (Bipolar I disorder ONLY in the case of Lamictal ODT) and either documentation of unsatisfactory effects with, intolerability to, or inability to take immediate-release lamotrigine, or in the case of Lamotrigine ER, the member is new to the health plan and has been established on therapy for longer than four weeks with Lamotrigine ER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years for Lamotrigine ER. 1 year for Lamictal ODT.
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of epilepsy or Bipolar I disorder (Bipolar I disorder ONLY in the case of Lamictal ODT)
Exclusion Criteria	
Required Medical Information	The member has a documented diagnosis of epilepsy or Bipolar I disorder (Bipolar I disorder ONLY in the case of Lamictal ODT) and either documentation of unsatisfactory effects with, intolerability to, or inability to take immediate-release lamotrigine, or in the case of Lamotrigine ER, the member is new to the health plan and has been established on therapy for longer than four weeks with Lamotrigine ER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years for Lamotrigine ER. 1 year for Lamictal ODT.
Other Criteria	
QL Criteria	6 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine ER

Products Affected

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

QL Criteria	3 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

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

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release 30 mg*

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

Lantus

Products Affected

- LANTUS

ST Criteria	Documented step through LEVEMIR VIAL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lantus SoloStar

Products Affected

- LANTUS SOLOSTAR

ST Criteria	Documented step through LEVEMIR VIAL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lastacaft

Products Affected

- LASTACAFT

QL Criteria	0.1 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Latanoprost

Products Affected

- *latanoprost ophthalmic*

QL Criteria	0.1 ML Per 1 Fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Latuda

Products Affected

- LATUDA

ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
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

Leena

Products Affected

- LEENA

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

Leflunomide

Products Affected

- *leflunomide oral*

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

Lessina

Products Affected

- LESSINA

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

Letairis

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Leuprolide Acetate

Products Affected

- *leuprolide acetate injection*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levaquin

Products Affected

- LEVAQUIN ORAL TABLET 500 MG

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

LevETIRAcetam ER

Products Affected

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

QL Criteria	4 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LevETIRAcetam ER

Products Affected

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

QL Criteria	6 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levitra

Products Affected

- LEVITRA

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

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride oral solution*

ST Criteria	Documented step through TWO of the following: CLARITIN OTC, ZYRTEC OTC, ALLEGRA OTC
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride oral tablet*

ST Criteria	Documented step through TWO of the following: CLARITIN OTC, ZYRTEC OTC, ALLEGRA OTC
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Levofloxacin

Products Affected

- *levofloxacin oral tablet*

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

Levonest

Products Affected

- LEVONEST

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

Levonorgest-Eth Estrad 91-Day

Products Affected

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

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

Levonorgestrel

Products Affected

- *levonorgestrel oral tablet 0.75 mg*

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

Levonorgestrel-Ethinyl Estrad

Products Affected

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

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

Levora 0.15/30 (28)

Products Affected

- LEVORA 0.15/30 (28)

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

Lialda

Products Affected

- LIALDA

ST Criteria	Documented failure, contraindication, or intolerance to APRISO
QL Criteria	4 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Next Generation Test

Products Affected

- LIBERTY NEXT GENERATION TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Test

Products Affected

- *liberty test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lindane

Products Affected

- *lindane external lotion*

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

Linzess

Products Affected

- LINZESS

ST Criteria	Documented step through LACTULOSE OR POLYETHYLENE GLYCOL
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

Lipofen

Products Affected

- LIPOFEN

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

Livalo

Products Affected

- LIVALO

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lo Loestrin Fe

Products Affected

- LO LOESTRIN FE

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

Lo/Ovral

Products Affected

- LO/OVRAL

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

Lo/Ovral (28)

Products Affected

- LO/OVRAL (28)

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

Loestrin 24 Fe

Products Affected

- LOESTRIN 24 FE

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

Loestrin Fe 1.5/30

Products Affected

- LOESTRIN FE 1.5/30

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

Loestrin Fe 1/20

Products Affected

- LOESTRIN FE 1/20

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

Lomedia 24 FE

Products Affected

- LOMEDIA 24 FE

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

LoSeasonique

Products Affected

- LOSEASONIQUE

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

Lovastatin

Products Affected

- *lovastatin*

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

Lovaza

Products Affected

- LOVAZA

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

Low-Ogestrel

Products Affected

- LOW-OGESTREL

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

Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION 0.01 %

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.1 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lumizyme

Products Affected

- LUMIZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lutera

Products Affected

- LUTERA

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

Lyrica

Products Affected

- LYRICA ORAL CAPSULE 100 MG, 25 MG, 200 MG, 150 MG, 75 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	Epilepsy as adjunct therapy, or diabetic peripheral neuropathy with documented failure of gabapentin, or post-herpetic neuropathy with documented failure of gabapentin, or documentation of the diagnosis of Fibromyalgia and documented failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.) and three (3) of the following drugs/drug classes: tricyclic antidepressant (eg: amitriptyline), muscle relaxant (eg: cyclobenzaprine), SSRI, SNRI, gabapentin, tramadol, or members with documented neuropathic pain associated with spinal cord injury with documented failure of three (3) of the following drugs/drug classes: tricyclic antidepressant (eg: amitriptyline), one muscle relaxant (eg: baclofen), SNRI, gabapentin, tramadol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	3 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lyrica

Products Affected

- LYRICA ORAL CAPSULE 225 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	Epilepsy as adjunct therapy, or diabetic peripheral neuropathy with documented failure of gabapentin, or post-herpetic neuropathy with documented failure of gabapentin, or documentation of the diagnosis of Fibromyalgia and documented failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.) and three (3) of the following drugs/drug classes: tricyclic antidepressant (eg: amitriptyline), muscle relaxant (eg: cyclobenzaprine), SSRI, SNRI, gabapentin, tramadol, or members with documented neuropathic pain associated with spinal cord injury with documented failure of three (3) of the following drugs/drug classes: tricyclic antidepressant (eg: amitriptyline), one muscle relaxant (eg: baclofen), SNRI, gabapentin, tramadol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lyrica

Products Affected

- LYRICA ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Diabetic peripheral neuropathy, Post-herpetic neuropathy, Fibromyalgia, Neuropathic pain associated with spinal cord injury
Exclusion Criteria	
Required Medical Information	Epilepsy as adjunct therapy, or diabetic peripheral neuropathy with documented failure of gabapentin, or post-herpetic neuropathy with documented failure of gabapentin, or documentation of the diagnosis of Fibromyalgia and documented failure of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.) and three (3) of the following drugs/drug classes: tricyclic antidepressant (eg: amitriptyline), muscle relaxant (eg: cyclobenzaprine), SSRI, SNRI, gabapentin, tramadol, or members with documented neuropathic pain associated with spinal cord injury with documented failure of three (3) of the following drugs/drug classes: tricyclic antidepressant (eg: amitriptyline), one muscle relaxant (eg: baclofen), SNRI, gabapentin, tramadol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	30 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lysteda

Products Affected

- LYSTEDA

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

Malathion

Products Affected

- *malathion external*

QL Criteria	59 LOTN Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Marlissa

Products Affected

- *marlissa*

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HR* 300 MG, 360 MG, 180 MG

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HR* 240 MG

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HR* 420 MG

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

Maxair Autohaler

Products Affected

- MAXAIR AUTOHALER

ST Criteria	Documented step through VENTOLIN HFA
QL Criteria	14 AERB Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Maxima Blood Glucose Test

Products Affected

- MAXIMA BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

MedroxyPROGESTERone Acetate

Products Affected

- *medroxyprogesterone acetate intramuscular**

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

Mefloquine HCl

Products Affected

- *mefloquine hcl*

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

Meijer Blood Glucose Test

Products Affected

- *meijer blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Meijer Premium Glucose Test

Products Affected

- *meijer premium glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Memantine HCl

Products Affected

- *memantine hcl oral tablet 5 (28)-10 (21) mg*

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

Memantine HCl

Products Affected

- *memantine hcl oral tablet 5 mg, 10 mg*

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

Menostar

Products Affected

- MENOSTAR

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

Mepron

Products Affected

- MEPRON

QL Criteria	210 ML Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metadate ER

Products Affected

- METADATE ER

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	3 TABS Per 1 DAY
Notes/ References	

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

Metaxalone

Products Affected

- *metaxalone*

QL Criteria	56 tablets Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metaxalone

Products Affected

- *metaxalone*

QL Criteria	56 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methamphetamine HCl

Products Affected

- *methamphetamine hcl*

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

Methylin

Products Affected

- METHYLIN ORAL TABLET CHEWABLE

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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

- *methylphenidate hcl er oral tablet extendedrelease* 10 mg, 20 mg*

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	3 TABS Per 1 DAY
Notes/ References	

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

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

Methylphenidate HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 tabs Per 1 DAY
Notes/ References	

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

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

Methylphenidate HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

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

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	

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

Methylphenidate HCl ER (LA)

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

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

Methylphenidate HCl ER (LA)

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

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

Metoprolol Succinate ER

Products Affected

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

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

Metoprolol Succinate ER

Products Affected

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

QL Criteria	1.5 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Metoprolol Succinate ER

Products Affected

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

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

Miacalcin

Products Affected

- MIACALCIN INJECTION

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Microdot Test

Products Affected

- MICRODOT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Microgestin 1.5/30

Products Affected

- MICROGESTIN 1.5/30

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

Microgestin 1/20

Products Affected

- MICROGESTIN 1/20

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

Microgestin FE 1.5/30

Products Affected

- MICROGESTIN FE 1.5/30

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

Microgestin FE 1/20

Products Affected

- MICROGESTIN FE 1/20

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

Mimvey

Products Affected

- MIMVEY

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

Minivelle

Products Affected

- MINIVELLE TRANSDERMAL PATCH BIWEEKLY 0.075 MG/24HR, 0.0375 MG/24HR

QL Criteria	0.29 patches Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Minivelle

Products Affected

- MINIVELLE TRANSDERMAL PATCH BIWEEKLY 0.1 MG/24HR, 0.05 MG/24HR

QL Criteria	0.29 PTTW Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Minivelle

Products Affected

- MINIVELLE TRANSDERMAL PATCH BIWEEKLY 0.025 MG/24HR

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

Mirapex ER

Products Affected

- MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HR* 0.375 MG, 1.5 MG, 0.75 MG, 2.25 MG, 3 MG, 3.75 MG

ST Criteria	Documented step through PRAMIPEXOLE
QL Criteria	1 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mircette

Products Affected

- MIRCETTE

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

Mirena

Products Affected

- MIRENA

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

Modafinil

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), shift work sleep disorder (SWSD)
Exclusion Criteria	Modafinil is not indicated to treat side effects caused by other medications.
Required Medical Information	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage), and the patient has failed an adequate trial of at least TWO of the following immediate release stimulants (all available generically): Dexedrine, Ritalin, or Adderall. FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSA, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy will be continued on a routine basis in combination with modafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patient's ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSA in conjunction with treating the daily fatigue
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	The plan also requires an unresponsive 2-week trial of 200mg per day dose before a 400mg per dose is authorized. (Doses up to 400mg/day given as a single dose have been well tolerated, but there is no consistent evidence that this dose confers additional benefit beyond that of the 200mg dose.)
QL Criteria	1 tabs Per 1 DAY

2015 Aetna Clinical Policy Bulletin - Individual Plan
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Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Moderiba

Products Affected

- MODERIBA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Modicon (28)

Products Affected

- MODICON (28)

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

Monoclate-P

Products Affected

- MONOCLATE-P

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Morphine Sulfate ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate ER Beads

Products Affected

- *morphine sulfate er beads oral capsule extended release 24 hour 90 mg, 120 mg, 75 mg, 45 mg*

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

Moxifloxacin HCl

Products Affected

- *moxifloxacin hcl oral*

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

Mozobil

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	Mobilizing hematopoeitic stem cells to peripheral blood for the purpose of collection and subsequent transplantation in patients with non-Hodgkins lymphoma and multiple myeloma
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

Multaq

Products Affected

- MULTAQ

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

Muse

Products Affected

- MUSE

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

MyGlucoHealth Test

Products Affected

- MYGLUCOHEALTH TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myobloc

Products Affected

- MYOBLOC

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myorisan

Products Affected

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

ST Criteria	Documented step through MINOCYCLINE OR DOXYCYCLINE
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

Myrbetriq

Products Affected

- MYRBETRIQ

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
QL Criteria	1 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myzilra

Products Affected

- MYZILRA

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

Naftifine HCl

Products Affected

- *naftifine hcl*

ST Criteria	Documented step through CLOTRIMAZOLE AND ECONAZOLE 1%
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naftin

Products Affected

- NAFTIN EXTERNAL 1 %
- NAFTIN EXTERNAL CREAM

ST Criteria	Documented step through CLOTRIMAZOLE AND ECONAZOLE 1%
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naglazyme

Products Affected

- NAGLAZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Namenda

Products Affected

- NAMENDA ORAL TABLET

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

Namenda Titration Pak

Products Affected

- NAMENDA TITRATION PAK

QL Criteria	1.75 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naratriptan HCl

Products Affected

- *naratriptan hcl*

QL Criteria	0.3 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nasonex

Products Affected

- NASONEX

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Natazia

Products Affected

- NATAZIA

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

Necon 0.5/35 (28)

Products Affected

- NECON 0.5/35 (28)

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

Necon 1/35 (28)

Products Affected

- NECON 1/35 (28)

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

Necon 1/50 (28)

Products Affected

- NECON 1/50 (28)

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

Necon 10/11 (28)

Products Affected

- NECON 10/11 (28)

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

Nesina

Products Affected

- NESINA

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupro

Products Affected

- NEUPRO

ST Criteria	Documented step through TWO of the following: GABAPENTIN, ROPINIROLE, PRAMIPEXOLE (covered without trials of Parkinson's)
QL Criteria	1 PT24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neutek 2Tek Glucose/Pressure

Products Affected

- NEUTEK 2TEK GLUCOSE/PRESSURE

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

Neutek 2Tek Test

Products Affected

- NEUTEK 2TEK TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nevirapine ER

Products Affected

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

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

NexAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexIUM

Products Affected

- NEXIUM ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	Rabeprazole up to 20 mg/day, Dexilant up to 60 mg/day, and Nexium up to 40 mg/day are available with prior-authorization when the following criteria is met: Step through Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. High Dose Nexium, Rabeprazole and Prevacid solutabs are available with prior-authorization when the following criteria is met: Nexium up to 80mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Rabeprazole up to 40mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Prevacid solutabs up to 60mg/day for members greater than 1 year old with documentation of: inability to swallow tablets/capsules and step through ONE of the following: 80mg/day of omeprazole (capsules may be opened and sprinkled on 1 tablespoon of applesauce), or 60mg/day of Prevacid 24H OTC (capsule may be opened and sprinkled on 1 tablespoon of applesauce, Ensure pudding, cottage cheese, yogurt, or strained pears, or emptied into 60mL of apple juice, orange juice, or tomato juice)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short Term course of high dose PPI 3-6 months. Long term course up to 1 Year.

PA Criteria	Criteria Details
Other Criteria	A step through one of these high dose therapies (80mg/day of Prilosec OTC/omeprazole or pantoprazole, OR 60mg/day of Prevacid 24H OTC) is required even if the member was previously approved for Rabeprazole, Prevacid solutabs, or Nexium at standard dosing. Exceptions may be considered if there is documentation of intolerance, e.g., side-effects or allergies to Prilosec OTC/omeprazole, pantoprazole, and Prevacid 24H OTC.
QL Criteria	1 packet Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nexplanon

Products Affected

- NEXPLANON

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

Next Choice

Products Affected

- NEXT CHOICE

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

Next Choice One Dose

Products Affected

- NEXT CHOICE ONE DOSE

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

Nicoderm CQ

Products Affected

- NICODERM CQ

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

Nicotine

Products Affected

- *nicotine*

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

Nicotine Polacrilex

Products Affected

- *nicotine polacrilex mouth/throat lozenge*

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

Nicotine Polacrilex

Products Affected

- *nicotine polacrilex mouth/throat gum*

QL Criteria	24 pieces Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotine Step 1

Products Affected

- *nicotine step 1*

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

Nicotine Step 2

Products Affected

- *nicotine step 2*

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

Nicotine Step 3

Products Affected

- *nicotine step 3*

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

Nicotrol

Products Affected

- NICOTROL

QL Criteria	16 cartridges Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotrol NS

Products Affected

- NICOTROL NS

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

Nifediac CC

Products Affected

- NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG, 90 MG

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

Nifediac CC

Products Affected

- NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG

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

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG

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

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

Nisoldipine ER

Products Affected

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

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

Nisoldipine ER

Products Affected

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

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

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hr* 25.5 mg*

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

Nitroglycerin

Products Affected

- *nitroglycerin translingual solution*

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

Nordette (28)

Products Affected

- NORDETTE (28)

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

Norethindrone-Eth Estradiol

Products Affected

- *norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg*

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

Norgestrel-Ethinyl Estradiol

Products Affected

- *norgestrel-ethinyl estradiol*

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

Norinyl 1+35 (28)

Products Affected

- NORINYL 1+35 (28)

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

Norinyl 1+50 (28)

Products Affected

- NORINYL 1+50 (28)

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

Noroxin

Products Affected

- NOROXIN

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

Nortrel 0.5/35 (28)

Products Affected

- NORTREL 0.5/35 (28)

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

Nortrel 1/35 (21)

Products Affected

- NORTREL 1/35 (21)

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

Nortrel 1/35 (28)

Products Affected

- NORTREL 1/35 (28)

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

Nova Max Glucose Test

Products Affected

- NOVA MAX GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Novarel

Products Affected

- NOVAREL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLIN 70/30

Products Affected

- NOVOLIN 70/30

ST Criteria	Documented step through HUMULIN Product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLIN 70/30 ReliOn

Products Affected

- NOVOLIN 70/30 RELION

ST Criteria	Documented step through HUMULIN Product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLIN N

Products Affected

- NOVOLIN N

ST Criteria	Documented step through HUMULIN Product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLIN N ReliOn

Products Affected

- NOVOLIN N RELION

ST Criteria	Documented step through HUMULIN Product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLIN R

Products Affected

- NOVOLIN R

ST Criteria	Documented step through HUMULIN Product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLIN R ReliOn

Products Affected

- NOVOLIN R RELION

ST Criteria	Documented step through HUMULIN Product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG

Products Affected

- NOVOLOG

ST Criteria	Documented step through HUMALOG product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG FlexPen

Products Affected

- NOVOLOG FLEXPEN

ST Criteria	Documented step through HUMALOG product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG Mix 70/30

Products Affected

- NOVOLOG MIX 70/30

ST Criteria	Documented step through HUMALOG product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG Mix 70/30 FlexPen

Products Affected

- NOVOLOG MIX 70/30 FLEXPEN

ST Criteria	Documented step through HUMALOG product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NovoLOG PenFill

Products Affected

- NOVOLOG PENFILL

ST Criteria	Documented step through HUMALOG product
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Noxafil

Products Affected

- NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of Invasive Aspergillosis, prophylaxis of invasive candidiasis, treatment of oropharyngeal candidiasis in patients with disease refractory
Exclusion Criteria	Noxafil is NOT covered for members who are pursuing for prophylaxis of invasive aspergillosis or candidiasis who are not severely immunocompromised, for patients less that 13 years of age, patients without refractory disease to first-line antifungal agents, concomitant use with ergot alkaloids, simvastatin, or sirolimus, or concomitant use with CYP3A4 substrates such as, pimozide and quinidine.
Required Medical Information	Noxafil is covered for members who meet any ONE of the following criteria: (1) Prophylaxis of Invasive Aspergillosis in severely immunocompromised patients with active disease, (2) Prophylaxis of Invasive Candidiasis in severely immunocompromised patients with a history of developing invasive candidiasis refractory to fluconazole or who are intolerant to fluconazole, or (3) Treatment of Oropharyngeal Candidiasis in patients with disease refractory to fluconazole or itraconazole.
Age Restrictions	13 years of age or greater
Prescriber Restrictions	
Coverage Duration	Invasive Aspergillosis/Candidiasis prophylaxis- 3 months, Oropharyngeal Candidiasis-13 days
Other Criteria	Refractory fungal infection is defined as a previous occurrence of disease which failed to improve or respond to a standard course of antifungal therapy. Patients started on Noxafil as an inpatient will be allowed to continue therapy on an outpatient basis without interruption. Initial therapy of one 105ml bottle (7-day supply) will be covered to assure that therapy is not delayed while the prior authorization request is being reviewed.
QL Criteria	105 SUSP Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2015 Aetna Clinical Policy Bulletin - Individual Plan
(Updated 12/01/2015)

Nucynta

Products Affected

- NUCYNTA

PA Criteria	Criteria Details
Covered Uses	Moderate to severe pain
Exclusion Criteria	Known or suspicious misuse of medications or illicit drug use.
Required Medical Information	Documented progression through the World Health Organization analgesic ladder, and step through, contraindication, or intolerance to two (2) alternative formulary immediate release opioids. Alternatives include morphine, oxycodone, hydromorphone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 3 years
Other Criteria	
QL Criteria	6 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucynta ER

Products Affected

- NUCYNTA ER

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	Treatment of pseudobulbar affect in patients with amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS).
Exclusion Criteria	Treatment in other types of emotional lability (i.e. Alzheimers disease and other dementias).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nulojix

Products Affected

- NULOJIX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/immunosuppressives.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuvigil

Products Affected

- NUVIGIL

PA Criteria	Criteria Details
Covered Uses	excessive daytime sleepiness, Shift Work Sleep Disorder
Exclusion Criteria	Nuvigil is not indicated to treat side effects caused by other medications.
Required Medical Information	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage), and the patient has failed an adequate trial of at least TWO of the following immediate release stimulants (all available generically): Dexedrine, Ritalin, or Adderall, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization). FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a standard diagnostic nocturnal polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and the patient must be compliant with recommendations for OSAHS treatment, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: The plan also requires an unresponsive 2-week trial of 150mg per day dose before a 250mg per day dose is authorized. (Doses up to 250 mg/day can be used but there is no solid evidence that it provides additional benefit beyond 150 mg/day.)

QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuvigil

Products Affected

- NUVIGIL

PA Criteria	Criteria Details
Covered Uses	excessive daytime sleepiness, Shift Work Sleep Disorder
Exclusion Criteria	Nuvigil is not indicated to treat side effects caused by other medications.
Required Medical Information	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage), and the patient has failed an adequate trial of at least TWO of the following immediate release stimulants (all available generically): Dexedrine, Ritalin, or Adderall, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization). FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a standard diagnostic nocturnal polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and the patient must be compliant with recommendations for OSAHS treatment, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: The plan also requires an unresponsive 2-week trial of 150mg per day dose before a 250mg per day dose is authorized. (Doses up to 250 mg/day can be used but there is no solid evidence that it provides additional benefit beyond 150 mg/day.)

QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ocella

Products Affected

- OCELLA

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

Octagam

Products Affected

- OCTAGAM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Octreotide Acetate

Products Affected

- *octreotide acetate*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ofloxacin

Products Affected

- *ofloxacin oral*

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

Ogestrel

Products Affected

- OGESTREL

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

OLANZapine

Products Affected

- *olanzapine oral*

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

OLANZapine

Products Affected

- *olanzapine oral*

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

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl*

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

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl*

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

Oleptro

Products Affected

- OLEPTRO

ST Criteria	Documented step through TRAZADONE
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

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

Omeprazole-Sodium Bicarbonate

Products Affected

- *omeprazole-sodium bicarbonate oral capsule 20-1100 mg*

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

Omnaris

Products Affected

- OMNARIS

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Omnitrope

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

On Call Plus Blood Glucose

Products Affected

- ON CALL PLUS BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

On Call Vivid Blood Glucose

Products Affected

- ON CALL VIVID BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron

Products Affected

- *ondansetron*

QL Criteria	0.4 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 4 mg, 24 mg*

QL Criteria	0.4 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron HCl

Products Affected

- *ondansetron hcl oral solution*

QL Criteria	1.67 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 8 mg*

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

OneTouch Test

Products Affected

- ONETOUCH TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OneTouch Ultra Blue

Products Affected

- ONETOUCH ULTRA BLUE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OneTouch Verio

Products Affected

- ONETOUCH VERIO IN VITRO STRIP

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onfi

Products Affected

- ONFI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onglyza

Products Affected

- ONGLYZA

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opana ER

Products Affected

- OPANA ER ORAL

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid treatment.
Exclusion Criteria	Known or suspicious misuse of medications or illicit drug use, no documented progression through the World Health Organization analgesic ladder, known hypersensitivity to the active ingredient present in the long acting agent.
Required Medical Information	For new members with chronic pain due to a malignant condition, if previously stabilized, or for moderate to severe pain meeting the following criteria: Documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 TAB Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opana ER

Products Affected

- OPANA ER ORAL

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid treatment.
Exclusion Criteria	Known or suspicious misuse of medications or illicit drug use, no documented progression through the World Health Organization analgesic ladder, known hypersensitivity to the active ingredient present in the long acting agent.
Required Medical Information	For new members with chronic pain due to a malignant condition, if previously stabilized, or for moderate to severe pain meeting the following criteria: Documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Optium Test

Products Affected

- OPTIUM TEST

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

OptiumEZ Test

Products Affected

- OPTIUMEZ TEST

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

Oravig

Products Affected

- ORAVIG

PA Criteria	Criteria Details
Covered Uses	Infection
Exclusion Criteria	
Required Medical Information	Have documented step through fluconazole, AND nystatin or clotrimazole troche
Age Restrictions	Less than 16 years old
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	14 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orencia

Products Affected

- ORENCIA INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunological agents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orkambi

Products Affected

- ORKAMBI

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

Orsythia

Products Affected

- ORSYTHIA

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

Ortho Diaphragm All-Flex

Products Affected

- ORTHO DIAPHRAGM ALL-FLEX

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

Ortho Micronor

Products Affected

- ORTHO MICRONOR

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

Ortho Tri-Cyclen (28)

Products Affected

- ORTHO TRI-CYCLEN (28)

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

Ortho Tri-Cyclen Lo

Products Affected

- ORTHO TRI-CYCLEN LO

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

Ortho-Cept (28)

Products Affected

- ORTHO-CEPT (28)

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

Ortho-Cyclen (28)

Products Affected

- ORTHO-CYCLEN (28)

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

Ortho-Novum 1/35 (28)

Products Affected

- ORTHO-NOVUM 1/35 (28)

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

Oseni

Products Affected

- OSENI

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ovcon-35 (28)

Products Affected

- OVCON-35 (28)

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

Ovcon-50

Products Affected

- OVCON-50

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

Oxtellar XR

Products Affected

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

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

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 600 MG

QL Criteria	4 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxybutynin Chloride

Products Affected

- *oxybutynin chloride oral tablet*

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

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er oral tablet extended release 24 hr* 5 mg*

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
QL Criteria	1 TB24 Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er oral tablet extended release 24 hr* 10 mg, 15 mg*

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
QL Criteria	2 TB24 Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyCODONE HCl ER

Products Affected

- *oxycodone hcl er*

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

Oxycodone-Ibuprofen

Products Affected

- *oxycodone-ibuprofen*

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

OxyCONTIN

Products Affected

- OXYCONTIN

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica (a trial of gabapentin is required before Lyrica or duloxetine is authorized for coverage), a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 05, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl

Products Affected

- *oxymorphone hcl*

PA Criteria	Criteria Details
Covered Uses	Moderate to severe pain
Exclusion Criteria	Oxymorphone is not covered for members with no documented progression through the World Health Organization analgesic ladder, who have not tried and failed three (2) alternative formulary opioids, or who have a known hypersensitivity to morphine analogs (e.g. codeine).
Required Medical Information	Documented progression through the World Health Organization analgesic ladder and step through, contraindication, or intolerance to two (2) alternative formulary immediate release opioids. Alternatives include morphine, oxycodone, hydromorphone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl ER

Products Affected

- *oxymorphone hcl er oral tablet extended release 12 hr* 10 mg*

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid treatment.
Exclusion Criteria	Known or suspicious misuse of medications or illicit drug use, no documented progression through the World Health Organization analgesic ladder, known hypersensitivity to the active ingredient present in the long acting agent.
Required Medical Information	For new members with chronic pain due to a malignant condition, if previously stabilized, or for moderate to severe pain meeting the following criteria: Documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl ER

Products Affected

- *oxymorphone hcl er oral tablet extended release 12 hr* 20 mg, 40 mg, 7.5 mg, 30 mg, 5 mg, 15 mg*

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid treatment.
Exclusion Criteria	Known or suspicious misuse of medications or illicit drug use, no documented progression through the World Health Organization analgesic ladder, known hypersensitivity to the active ingredient present in the long acting agent.
Required Medical Information	For new members with chronic pain due to a malignant condition, if previously stabilized, or for moderate to severe pain meeting the following criteria: Documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	4 TABS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hr* 6 mg*

ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hr* 1.5 mg, 9 mg, 3 mg*

ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
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

Pancreaze

Products Affected

- PANCREAZE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pancrelipase (Lip-Prot-Amyl)

Products Affected

- *pancrelipase (lip-prot-amyl)*

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paragard Intrauterine Copper

Products Affected

- PARAGARD INTRAUTERINE COPPER

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

Paricalcitol

Products Affected

- *paricalcitol oral*

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

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 20 mg, 10 mg*

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

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 mg*

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hr* 25 mg*

ST Criteria	Documented step through paroxetine
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hr* 12.5 mg, 37.5 mg*

ST Criteria	Documented step through paroxetine
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PEG 3350/Electrolytes

Products Affected

- *peg 3350/electrolytes*

QL Criteria	4000 SOLR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PEG-3350/Electrolytes

Products Affected

- *peg-3350/electrolytes*

QL Criteria	4000 SOLR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pegasys

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pegasys ProClick

Products Affected

- PEGASYS PROCLICK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Peg-Intron

Products Affected

- PEG-INTRON

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Peg-Intron Redipen

Products Affected

- PEG-INTRON REDIPEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Peg-Intron Redipen Pak 4

Products Affected

- PEG-INTRON REDIPEN PAK 4

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 250 MG

ST Criteria	Documented failure, contraindication, or intolerance to APRISO
QL Criteria	16 CAPS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 500 MG

ST Criteria	Documented failure, contraindication, or intolerance to APRISO
QL Criteria	8 CAPS Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Perforomist

Products Affected

- PERFOROMIST

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	Documented physical limitation that prevents the use of a non-nebulized long-acting bronchodilator with or without use of a spacer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	4 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Perindopril Erbumine

Products Affected

- *perindopril erbumine oral tablet 8 mg*

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

Perindopril Erbumine

Products Affected

- *perindopril erbumine oral tablet 2 mg, 4 mg*

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

Pertzye

Products Affected

- PERTZYE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pharmacist Choice Autocode

Products Affected

- PHARMACIST CHOICE AUTOCODE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Phendimetrazine Tartrate

Products Affected

- *phendimetrazine tartrate*

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Phendimetrazine Tartrate ER

Products Affected

- *phendimetrazine tartrate er*

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Phentermine HCl

Products Affected

- *phentermine hcl oral*

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Philith

Products Affected

- PHILITH

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

Picato

Products Affected

- PICATO EXTERNAL 0.015 %

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

Picato

Products Affected

- PICATO EXTERNAL 0.05 %

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

Pioglitazone HCl

Products Affected

- *pioglitazone hcl*

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

Pioglitazone HCl-Glimepiride

Products Affected

- *pioglitazone hcl-glimepiride*

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

Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-metformin hcl*

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

Plan B

Products Affected

- PLAN B

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

Plan B One-Step

Products Affected

- PLAN B ONE-STEP

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

PocketChem EZ Test

Products Affected

- POCKETCHEM EZ TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pomalyst

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Portia-28

Products Affected

- PORTIA-28

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

Potiga

Products Affected

- POTIGA ORAL TABLET 200 MG, 300 MG, 400 MG

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

Potiga

Products Affected

- POTIGA ORAL TABLET 50 MG

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

Pradaxa

Products Affected

- PRADAXA

ST Criteria	Documented step through WARFARIN
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

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er*

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

PrandiMet

Products Affected

- PRANDIMET

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

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

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

Precision PCx

Products Affected

- PRECISION PCX

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

Precision PCX Plus Test

Products Affected

- PRECISION PCX PLUS TEST

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

Precision Point of Care Test

Products Affected

- PRECISION POINT OF CARE TEST

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

Precision QID Test

Products Affected

- PRECISION QID TEST

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

Precision Xtra Blood Glucose

Products Affected

- PRECISION XTRA BLOOD GLUCOSE

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

Prefest

Products Affected

- PREFEST

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

Premarin

Products Affected

- PREMARIN ORAL

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

Premphase

Products Affected

- PREMPHASE

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

Prempro

Products Affected

- PREMPRO

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

Prestige Smart System Test

Products Affected

- *prestige smart system test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prestige Test

Products Affected

- PRESTIGE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prevacid

Products Affected

- PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG

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

Prezista

Products Affected

- PREZISTA ORAL TABLET 75 MG, 400 MG, 600 MG, 150 MG

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

Prezista

Products Affected

- PREZISTA ORAL SUSPENSION

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

Prezista

Products Affected

- PREZISTA ORAL TABLET 800 MG

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

Pristiq

Products Affected

- PRISTIQ

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	Patients taking products containing venlafaxine concomitantly, patients taking MAOIs concomitantly, or for use in pediatrics.
Required Medical Information	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses, or patient is a new member and has been receiving Pristiq therapy for more than 4 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Privigen

Products Affected

- PRIVIGEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/ivig.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ProAir HFA

Products Affected

- PROAIR HFA

ST Criteria	Documented step through VENTOLIN HFA
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ProAir RespiClick

Products Affected

- PROAIR RESPICLICK

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

ProCentra

Products Affected

- PROCENTRA

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

Procrit

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Erythropoiesis_Stimulating_Agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prodigy AutoCode Blood Glucose

Products Affected

- PRODIGY AUTOCODE BLOOD GLUCOSE
  IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prodigy No Coding Blood Gluc

Products Affected

- PRODIGY NO CODING BLOOD GLUC

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Profilnine SD

Products Affected

- PROFILNINE SD

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Progesterone Micronized

Products Affected

- *progesterone micronized oral*

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

Prolastin

Products Affected

- PROLASTIN

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

Prolastin-C

Products Affected

- PROLASTIN-C

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

Proleukin

Products Affected

- PROLEUKIN

PA Criteria	Criteria Details
Covered Uses	Metastatic melanoma OR Metastatic renal cell carcinoma
Exclusion Criteria	Experimental and investigational for the treatment of the following conditions (not an all inclusive list): Acute myeloid leukemia, Atopic dermatitis, Bladder cancer, Cutaneous T-cell lymphoma, Endometriomas, Graft-versus-host disease, HIV infection, Juvenile rheumatoid arthritis, Mycosis fungoides, MYH9 (May-Hegglin) platelet disorder, Neuroblastoma, Pancreatic cancer.
Required Medical Information	Metastatic melanoma or metastatic renal cell carcinoma
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prolia

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/promacta.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Promacta

Products Affected

- PROMACTA

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

Propafenone HCl ER

Products Affected

- *propafenone hcl er*

QL Criteria	2 CP12 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Protopic

Products Affected

- PROTOPIC

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Children less than 2 years of age. Children and adults with weakened immune systems. Documentation of hypersensitivity to pimecrolimus, tacrolimus or any component in the product. Those with Netherton?s syndrome.
Required Medical Information	A. Adults: trial and failure of at least one formulary topical corticosteroid of medium to high, OR B. Children (? 2 years of age): trial and failure of at least one formulary low potency topical corticosteroid, OR C. Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas, OR D. Documentation of a contraindication to topical corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3.34 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Proventil HFA

Products Affected

- PROVENTIL HFA

ST Criteria	Documented step through VENTOLIN HFA
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pulmozyme

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	5 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl

Products Affected

- QNASL

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qnasl Childrens

Products Affected

- QNASL CHILDRENS

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Qsymia

Products Affected

- QSYMIA

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 cap Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Quasense

Products Affected

- QUASENSE

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg, 300 mg, 100 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 400 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 50 mg*

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

Quillivant XR

Products Affected

- QUILLIVANT XR

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	12 ml Per 1 DAY
Notes/ References	

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

QuiNINE Sulfate

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Covered Uses	Malaria, babesiosis
Exclusion Criteria	Qualaquin is NOT covered for use for leg cramps, in women who are pregnant, or in patients with cerebral malaria in combination with doxycycline, tetracycline, or clindamycin (members should be treated with IV quinine per CDC (not oral).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MALARIA - 7 days (42 capsules). BABESIOSIS - 10 days (60 capsules).
Other Criteria	
QL Criteria	42 CAPS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RA Nicotine

Products Affected

- *ra nicotine transdermal*

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

RA TRUEtest Test

Products Affected

- RA TRUETEST TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Zollinger-Ellison syndrome, Uncomplicated gastroesophageal reflux desease (Gerd) with breakthrough symptoms, Complicated GERD and other higher risk conditions such as feflux-associated laryngitis, recent gastroinestinal bleed, grade 3 or 4 erosive esophagitis, or GERD exacerbated asthma.
Exclusion Criteria	Non-Covered uses include uses not approved by the FDA, or if use is unapproved and not supported by the literature or evidence as an accepted off-label use (see Off-Label Use Policy for determining accepted use). Quantity levels exceeding the quantity limitations on PPIs, Dexilant dosing exceeding 60mg/day
Required Medical Information	Rabeprazole up to 20 mg/day, Dexilant up to 60 mg/day, and Nexium up to 40 mg/day are available with prior-authorization when the following criteria is met: Step through Prilosec OTC/omeprazole, Prevacid 24H OTC, and pantoprazole. High Dose Nexium, Rabeprazole and Prevacid solutabs are available with prior-authorization when the following criteria is met: Nexium up to 80mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Rabeprazole up to 40mg/day with documentation of step through of one of the following high dose agents: 80 mg/day of Prilosec OTC/omeprazole or pantoprazole or 60mg/day of Prevacid 24H OTC, Prevacid solutabs up to 60mg/day for members greater than 1 year old with documentation of: inability to swallow tablets/capsules and step through ONE of the following: 80mg/day of omeprazole (capsules may be opened and sprinkled on 1 tablespoon of applesauce), or 60mg/day of Prevacid 24H OTC (capsule may be opened and sprinkled on 1 tablespoon of applesauce, Ensure pudding, cottage cheese, yogurt, or strained pears, or emptied into 60mL of apple juice, orange juice, or tomato juice)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short Term course of high dose PPI 3-6 months. Long term course up to 1 Year.

PA Criteria	Criteria Details
Other Criteria	A step through one of these high dose therapies (80mg/day of Prilosec OTC/omeprazole or pantoprazole, OR 60mg/day of Prevacid 24H OTC) is required even if the member was previously approved for Rabeprazole, Prevacid solutabs, or Nexium at standard dosing. Exceptions may be considered if there is documentation of intolerance, e.g., side-effects or allergies to Prilosec OTC/omeprazole, pantoprazole, and Prevacid 24H OTC.
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ranexa

Products Affected

- RANEXA

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

Rapaflo

Products Affected

- RAPAFLO

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

Ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	17.5 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 27, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rayos

Products Affected

- RAYOS

ST Criteria	Documented step through PREDNISONE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebetol

Products Affected

- REBETOL ORAL SOLUTION

QL Criteria	500 SOLN Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reclast

Products Affected

- RECLAST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reclipsen

Products Affected

- RECLIPSEN

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

Recombinate

Products Affected

- RECOMBINATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rectiv

Products Affected

- RECTIV

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

RefuAH Plus Blood Glucose Test

Products Affected

- REFUAH PLUS BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Regimex

Products Affected

- REGIMEX

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Relenza Diskhaler

Products Affected

- RELENZA DISKHALER

QL Criteria	40 disks Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ReliOn Confirm/micro Test

Products Affected

- RELION CONFIRM/MICRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ReliOn Prime Test

Products Affected

- RELION PRIME TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ReliOn Ultima Test

Products Affected

- RELION ULTIMA TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation
Exclusion Criteria	
Required Medical Information	Patients with advanced illness who are receiving palliative care, for the treatment of opioid-induced constipation when response to laxative therapy has not been sufficient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relpax

Products Affected

- RELPAX

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	0.2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remicade

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunological agents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Remodulin

Products Affected

- REMODULIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rescula

Products Affected

- RESCULA

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.17 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Restasis

Products Affected

- RESTASIS

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

Reveal Blood Glucose Test

Products Affected

- REVEAL BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Revlimid

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rexall Blood Glucose Test

Products Affected

- REXALL BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rexulti

Products Affected

- REXULTI

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

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 300 MG, 150 MG

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

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 200 MG

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

RiaSTAP

Products Affected

- RIASTAP

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ribasphere

Products Affected

- RIBASPHERE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ribavirin

Products Affected

- *ribavirin oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rightest GS100 Blood Glucose

Products Affected

- RIGHTEST GS100 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rightest GS300 Blood Glucose

Products Affected

- RIGHTEST GS300 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rightest GS550 Blood Glucose

Products Affected

- RIGHTEST GS550 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.04 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 35 mg*
- *risedronate sodium oral tablet delayed release*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	4 tablets Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 5 mg, 30 mg*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral tablet 2 mg, 1 mg, 0.25 mg, 0.5 mg*
- *risperidone oral tablet dispersible 2 mg, 0.5 mg, 1 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet 3 mg*
- *risperidone oral tablet dispersible 3 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet dispersible 0.25 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet dispersible 4 mg*
- *risperidone oral tablet 4 mg*

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

Rivastigmine

Products Affected

- *rivastigmine*

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

Rivastigmine Tartrate

Products Affected

- *rivastigmine tartrate*

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

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

QL Criteria	0.4 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release 24 hr* 12 mg*

ST Criteria	Documented step through ROPINIROLE HCL
QL Criteria	2 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release 24 hr* 6 mg, 2 mg, 4 mg, 8 mg*

ST Criteria	Documented step through ROPINIROLE HCL
QL Criteria	1 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rozerem

Products Affected

- ROZEREM

PA Criteria	Criteria Details
Covered Uses	Insomnia
Exclusion Criteria	
Required Medical Information	Step through either zolpidem tartrate or zalelpon, and through zolpidem tartrate extended-release
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/anticonvulasants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/anticonvulasants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 PACK Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Safyral

Products Affected

- SAFYRAL

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

Samsca

Products Affected

- SAMSCA ORAL TABLET 15 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Samsca

Products Affected

- SAMSCA ORAL TABLET 30 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/samsca.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sancuso

Products Affected

- SANCUSO

PA Criteria	Criteria Details
Covered Uses	Chemotherapy induced nausea and vomiting
Exclusion Criteria	Cancer patients with non-chemotherapy related nausea and vomiting, patients with radiation-induced nausea and vomiting, patients with pregnancy-related nausea and vomiting, patients with post-operative nausea and vomiting
Required Medical Information	Patient is currently receiving chemotherapy and remains symptomatic despite treatment with oral ondansetron (Zofran) or oral granisetron (Kytril) or have documented inability to take oral antiemetics, including ODT formulations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	0.05 patch Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saphris

Products Affected

- SAPHRIS

ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saphris

Products Affected

- SAPHRIS

ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella

Products Affected

- SAVELLA

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	Peripheral Neuropathy(s) (other than diabetic), General Anxiety Disorder or Panic Disorder, Post-operative pain
Required Medical Information	Documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), and trial and failure of three (3) medications from the following drugs/drug classes: one tricyclic antidepressant (eg: amitriptyline), one muscle relaxant (eg: cyclobenzaprine), one SSRI, one SNRI, gabapentin, and tramadol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella Titration Pack

Products Affected

- SAVELLA TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	Peripheral Neuropathy(s) (other than diabetic), General Anxiety Disorder or Panic Disorder, Post-operative pain
Required Medical Information	Documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), and trial and failure of three (3) medications from the following drugs/drug classes: one tricyclic antidepressant (eg: amitriptyline), one muscle relaxant (eg: cyclobenzaprine), one SSRI, one SNRI, gabapentin, and tramadol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Seasonale

Products Affected

- SEASONALE

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

Seasonique

Products Affected

- SEASONIQUE

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

Selzentry

Products Affected

- SELZENTRY

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

Sensipar

Products Affected

- SENSIPAR

ST Criteria	Documented step through CALCITRIOL (covered without trials for hyperparathyroidism and parathyroid carcinoma)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Serevent Diskus

Products Affected

- SEREVENT DISKUS

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

Serophene

Products Affected

- SEROPHENE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/infertility.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 400 MG, 50 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder (MDD), Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	FOR MAJOR DEPRESSIVE DISORDER: Documented failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses and documented failure or unresponsiveness to ONE of the following atypical antipsychotics: Geodon, Risperdal, Seroquel, Zyprexa, or Latuda. FOR BIPOLAR DISORDER OR SCHIZOPHRENIA: Documented failure or unresponsiveness to TWO of the following atypical antipsychotics: Geodon, Risperdal, Seroquel, or Zyprexa, and Latuda
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	2 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 200 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder (MDD), Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	FOR MAJOR DEPRESSIVE DISORDER: Documented failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses and documented failure or unresponsiveness to ONE of the following atypical antipsychotics: Geodon, Risperdal, Seroquel, Zyprexa, or Latuda. FOR BIPOLAR DISORDER OR SCHIZOPHRENIA: Documented failure or unresponsiveness to TWO of the following atypical antipsychotics: Geodon, Risperdal, Seroquel, or Zyprexa, and Latuda
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral concentrate*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

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

Sildenafil Citrate

Products Affected

- *sildenafil citrate oral*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simcor

Products Affected

- SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 500-20 MG, 750-20 MG, 1000-20 MG

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	3 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simcor

Products Affected

- SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 1000-40 MG, 500-40 MG

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simponi

Products Affected

- SIMPONI SUBCUTANEOUS* 50 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunological agents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	0.02 ML Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simulect

Products Affected

- SIMULECT

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

Simvastatin

Products Affected

- *simvastatin oral*

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

SM Nicotine

Products Affected

- *sm nicotine transdermal*

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

Smart Diabetes Xpres Test

Products Affected

- SMART DIABETES XPRES TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Smartest Blood Glucose Test

Products Affected

- SMARTEST BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate*

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

Solia

Products Affected

- SOLIA

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

Solus V2 Test

Products Affected

- SOLUS V2 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Somatuline Depot

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/Sandostatin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Spiriva HandiHaler

Products Affected

- SPIRIVA HANDIHALER

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

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT

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

Sporanox

Products Affected

- SPORANOX ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	Onychomycosis, invasive fungal infection, uther fungal infection, superficial mycoses
Exclusion Criteria	Cosmetic use, patients with evidence of ventricular dysfunction such as CHF or a history of CHF. Coadministration with certain drugs metabolized by the cytochrome P-450 3A4 isoenzyme system (CYP3A4), cisapride, oral midazolam, pimozide, quinidine, dofetilide, triazolam, HMG-CoA reductase inhibitors metabolized by CYP3A4, such as lovastatin and simvastatin, and ergot alkaloids metabolized by CYP3A4, such as dihydroergotamine, ergotamine, ergonovine, and methylergonovine.
Required Medical Information	Itraconazole Capsules are covered for members who meet the following criteria: (1) Invasive fungal infections in patients who are immunocompromised, such as histoplamosis, aspergillosis, and blastomycosis, (2) Treatment of tinea barbae, tinea capitis, tinea favosa with previous treatment with terbinafine, (3) Treatment of tinea corporis, tinea cruris, tinea faciei, tinea manuum, tinea pedis with previous treatment with a topical antifungal and terbinafine, (4) Treatment of tinea versicolor with previous treatment with selenium sulfide and a topcial antifungal, (5) a diagnosis of majocchi granuloma, (6) Onychomycosis in diabetic patients or patients with peripheral vascular disease and either a positive onychomycosis susceptible pathogen culture or a positive PAS stain performed by a laboratory and documented trial/failure of terbinafine (generic Lamisil), or (7) Onychomycosis with documented disabling pain or impairment and a positive onychomycosis susceptible pathogen culture and documented step through terbinafine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Nail: 12 wk(toe),5 wk (finger) per year,Invasive: 1-3 mo based on severity, Other Dx: 1-6 wk
Other Criteria	
Notes/ References	

Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sprintec 28

Products Affected

- SPRINTEC 28

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

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 20 MG, 80 MG, 50 MG, 70 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sronyx

Products Affected

- SRONYX

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

Stavzor

Products Affected

- STAVZOR

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar disorder, Prophylaxis of migraine headaches
Exclusion Criteria	
Required Medical Information	FOR EPILEPSY OR BIPOLAR DISORDER: documentation of step through valproic acid capsules or divalproex sodium delayed release tablets. FOR PROPHYLAXIS OF MIGRAINE HEADACHES: documentation of step through 2 of the following: valproic acid capsules or divalproex sodium delayed release tablets, propranolol, or topiramate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Staxyn

Products Affected

- STAXYN

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

Stimate

Products Affected

- STIMATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/miscendocrine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stiolto Respimat

Products Affected

- STIOLTO RESPIMAT

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

Stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strattera

Products Affected

- STRATTERA

ST Criteria	Documented step through a STIMULANT
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Striant

Products Affected

- STRIANT

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	2 MISC Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stribild

Products Affected

- STRIBILD

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of human immunodeficiency virus (HIV), AND a 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/continuations ONLY). For treatment naïve patients only, 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 one of the preferred regimens: Triumeq (dolutegravir/abacavir/lamivudine) OR Tivicay (dolutegravir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine) OR Isentress (Raltegravir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine) OR Prezista (Darunavir) plus Norvir (ritonavir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 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
Covered Uses	Opioid Dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	3 film Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3 MG

PA Criteria	Criteria Details
Covered Uses	Opioid Dependence
Exclusion Criteria	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
Required Medical Information	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months = current enrollement

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	2 film Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SulfaSALAzine

Products Affected

- *sulfasalazine oral*

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

Sulfazine

Products Affected

- SULFAZINE

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

Sulfazine EC

Products Affected

- SULFAZINE EC

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

SUMAtriptan

Products Affected

- *sumatriptan nasal*

QL Criteria	0.21 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate oral*

QL Criteria	0.3 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous**
- *sumatriptan succinate subcutaneous* solution 4 mg/0.5ml*

QL Criteria	0.14 BOXES Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous* solution 6 mg/0.5ml*

QL Criteria	0.17 Syringe Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous**

QL Criteria	0.14 Syringe Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill*

QL Criteria	0.14 Syringe Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill*

QL Criteria	0.14 BOXES Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suprax

Products Affected

- SUPRAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML

QL Criteria	75 SUSR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suprax

Products Affected

- SUPRAX ORAL TABLET

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

Suprax

Products Affected

- SUPRAX ORAL TABLET CHEWABLE

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

Suprax

Products Affected

- SUPRAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML

QL Criteria	50 SUSR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suprax

Products Affected

- SUPRAX ORAL TABLET CHEWABLE

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

Sure Edge Test

Products Affected

- SURE EDGE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SureChek Blood Glucose Test

Products Affected

- SURECHEK BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SureStep Pro Test

Products Affected

- SURESTEP PRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SureStep Test

Products Affected

- SURESTEP TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sure-Test EasyPlus Mini Test

Products Affected

- SURE-TEST EASYPLUS MINI TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Symbicort

Products Affected

- SYMBICORT

ST Criteria	Documented step through DULERA (covered without trials for COPD)
QL Criteria	0.34 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SymlinPen 120

Products Affected

- SYMLINPEN 120

PA Criteria	Criteria Details
Covered Uses	Type 1 and Type 2 diabetes
Exclusion Criteria	
Required Medical Information	FOR TYPE 1 DIABETES: Patient must be using both basal insulin and short-acting insulin, and require three or more insulin injections daily, or using an insulin pump. FOR TYPE 2 DIABETES: Patient is receiving maximum tolerated doses of metformin, unless the patient is not a candidate for metformin therapy, and is using both basal insulin and short-acting insulin, and requires three or more insulin injections daily or is using an insulin pump, and failure to achieve adequate glycemic control despite individualized insulin management, defined as an A1C level is greater than 7% and less than 9%, and marked day-to-day variability in glucose levels (based on review of self-monitoring blood glucose levels), and home blood glucose monitoring is carried out three or more times per day, and is currently receiving individualized medical nutrition therapy by a registered dietician (requiring total daily carbohydrate intake monitoring), and is currently receiving ongoing care under the guidance of a healthcare professional skilled in the use of insulin and supported by the services of diabetes educators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Discontinuation Criteria includes recurrent unexplained hypoglycemia that requires medical assistance, persistent clinically significant nausea or associated abdominal pain, noncompliance with self-monitoring of blood glucose concentrations, noncompliance with insulin dose adjustments, or non compliance with scheduled health care professional contacts or recommended clinic visits
QL Criteria	4 pens Per 1 fill
Notes/ References	

Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SymlinPen 60

Products Affected

- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	Type 1 and Type 2 diabetes
Exclusion Criteria	
Required Medical Information	FOR TYPE 1 DIABETES: Patient must be using both basal insulin and short-acting insulin, and require three or more insulin injections daily, or using an insulin pump. FOR TYPE 2 DIABETES: Patient is receiving maximum tolerated doses of metformin, unless the patient is not a candidate for metformin therapy, and is using both basal insulin and short-acting insulin, and requires three or more insulin injections daily or is using an insulin pump, and failure to achieve adequate glycemic control despite individualized insulin management, defined as an A1C level is greater than 7% and less than 9%, and marked day-to-day variability in glucose levels (based on review of self-monitoring blood glucose levels), and home blood glucose monitoring is carried out three or more times per day, and is currently receiving individualized medical nutrition therapy by a registered dietician (requiring total daily carbohydrate intake monitoring), and is currently receiving ongoing care under the guidance of a healthcare professional skilled in the use of insulin and supported by the services of diabetes educators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Discontinuation Criteria includes recurrent unexplained hypoglycemia that requires medical assistance, persistent clinically significant nausea or associated abdominal pain, noncompliance with self-monitoring of blood glucose concentrations, noncompliance with insulin dose adjustments, or non compliance with scheduled health care professional contacts or recommended clinic visits
QL Criteria	4 pens Per 1 fill
Notes/ References	

Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synagis

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/Synagis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Synribo

Products Affected

- SYNRIBO

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

Taclonex

Products Affected

- TACLONEX EXTERNAL SUSPENSION

ST Criteria	Documented step through CALCIPOTRIENE AND MEDIUM TO HIGH POTENCY TOPICAL STEROID
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tacrolimus

Products Affected

- *tacrolimus external*

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Children less than 2 years of age. Children and adults with weakened immune systems. Documentation of hypersensitivity to pimecrolimus, tacrolimus or any component in the product. Those with Netherton?s syndrome.
Required Medical Information	A. Adults: trial and failure of at least one formulary topical corticosteroid of medium to high, OR B. Children (? 2 years of age): trial and failure of at least one formulary low potency topical corticosteroid, OR C. Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas, OR D. Documentation of a contraindication to topical corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	60 GM Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: September 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tamiflu

Products Affected

- TAMIFLU ORAL CAPSULE

QL Criteria	20 CAPS Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tamiflu

Products Affected

- TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML

QL Criteria	480 ml Per 365 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tarceva

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Targretin

Products Affected

- TARGRETIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tasigna

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tazorac

Products Affected

- TAZORAC

ST Criteria	Documented step through TRETINOIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 360 MG, 300 MG, 180 MG

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

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Technivie

Products Affected

- TECHNIVIE

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

Tekamlo

Products Affected

- TEKAMLO

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

Tekturna

Products Affected

- TEKTURNA

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

Tekturna HCT

Products Affected

- TEKTURNA HCT

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

Telcare Blood Glucose Test

Products Affected

- TELCARE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Telmisartan

Products Affected

- *telmisartan*

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

Telmisartan-Amlodipine

Products Affected

- *telmisartan-amlodipine*

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

Telmisartan-HCTZ

Products Affected

- *telmisartan-hctz*

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

Temazepam

Products Affected

- *temazepam oral capsule 22.5 mg, 7.5 mg*

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

Temozolomide

Products Affected

- *temozolomide*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testim

Products Affected

- TESTIM

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	5 GEL Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testopel

Products Affected

- TESTOPEL

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal 10 mg/act (2%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
QL Criteria	4 pumps Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone

Products Affected

- *testosterone transdermal 12.5 mg/act (1%), 50 mg/5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
ST Criteria	Trial of preferred product, Testim
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testosterone Cypionate

Products Affected

- *testosterone cypionate intramuscular* solution 250 mg/ml*

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

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg*

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

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 25 mg*

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

Teveten HCT

Products Affected

- TEVETEN HCT

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

TGT Blood Glucose Test

Products Affected

- *tgt blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TGT Nicotine Step One

Products Affected

- *tgt nicotine step one*

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

TGT Nicotine Step Three

Products Affected

- *tgt nicotine step three*

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

TGT Nicotine Step Two

Products Affected

- *tgt nicotine step two*

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

Thalomid

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Theo-24

Products Affected

- THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 2 mg*

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 4 mg*

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

Tilia Fe

Products Affected

- TILIA FE

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

Tinidazole

Products Affected

- *tinidazole oral tablet 500 mg*

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

Tinidazole

Products Affected

- *tinidazole oral tablet 250 mg*

QL Criteria	24 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tirosint

Products Affected

- TIROSINT

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

Tobramycin

Products Affected

- *tobramycin inhalation*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/pulmozyme.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	10 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tolterodine Tartrate

Products Affected

- *tolterodine tartrate*

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
QL Criteria	1 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Topiramate

Products Affected

- *topiramate oral capsule sprinkle*

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

Toviaz

Products Affected

- TOVIAZ

ST Criteria	Documented step through OXYBUTYNIN or TROSPIUM AND VESICARE or MYRBETRIQ
QL Criteria	1 TB24 Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tracleer

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tradjenta

Products Affected

- TRADJENTA

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral tablet extended release 24 hr**

ST Criteria	Documented step through TRAMADOL
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TraMADol HCl ER (Biphasic)

Products Affected

- *tramadol hcl er (biphasic)*

ST Criteria	Documented step through TRAMADOL
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tramadol-Acetaminophen

Products Affected

- *tramadol-acetaminophen*

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

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

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

Travatan Z

Products Affected

- TRAVATAN Z

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	0.1 ml Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin

Products Affected

- *tretinoin external 0.05 %*

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

Tretinoin

Products Affected

- *tretinoin external 0.01 %*

QL Criteria	1.67 GM Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin

Products Affected

- *tretinoin external 0.025 %*
- *tretinoin external cream*

QL Criteria	1.67 gm Per 1 DAY
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 0.0375 %

ST Criteria	Documented step through TRETINOIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretten

Products Affected

- TRETTEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triamcinolone Acetonide

Products Affected

- *triamcinolone acetonide external*

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tribenzor

Products Affected

- TRIBENZOR

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

Triglide

Products Affected

- TRIGLIDE ORAL TABLET 50 MG

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

Tri-Legest Fe

Products Affected

- TRI-LEGEST FE

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

Tri-Sprintec

Products Affected

- TRI-SPRINTEC

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

Trivora (28)

Products Affected

- TRIVORA (28)

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

Trospium Chloride

Products Affected

- *trospium chloride*

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

Trospium Chloride ER

Products Affected

- *trospium chloride er*

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

TRUEtest Test

Products Affected

- TRUETEST TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TrueTrack Test

Products Affected

- TRUETRACK TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Truvada

Products Affected

- TRUVADA

PA Criteria	Criteria Details
Covered Uses	HIV Infection, HIV Infection Pre-exposure Prophylaxis
Exclusion Criteria	Truvada is NOT covered for a use not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use)
Required Medical Information	Truvada is covered for members who have 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 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 or equal to 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HIV-1 infection: 3 years. Pre-exposure prophylaxis: 3 months.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tudorza Pressair

Products Affected

- TUDORZA PRESSAIR

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

TussiCaps

Products Affected

- TUSSICAPS

QL Criteria	20 CP12 Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tykerb

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyvaso

Products Affected

- TYVASO

QL Criteria	2.9 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyvaso Refill

Products Affected

- TYVASO REFILL

QL Criteria	2.9 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyvaso Starter

Products Affected

- TYVASO STARTER

QL Criteria	2.9 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyzeka

Products Affected

- TYZEKA

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

Uceris

Products Affected

- UCERIS ORAL

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

Ulesfia

Products Affected

- ULESFIA

QL Criteria	681 LOTN Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uloric

Products Affected

- ULORIC

ST Criteria	Documented step through ALLOPURINOL
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultima Test

Products Affected

- ULTIMA TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK PRO Test

Products Affected

- ULTRATRAK PRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK Ultimate Test

Products Affected

- ULTRATRAK ULTIMATE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultresa

Products Affected

- ULTRESA

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ValACYclovir HCl

Products Affected

- *valacyclovir hcl oral tablet 1 gm*

QL Criteria	21 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ValACYclovir HCl

Products Affected

- *valacyclovir hcl oral tablet 500 mg*

QL Criteria	42 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valcyte

Products Affected

- VALCYTE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl*

QL Criteria	102 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valsartan

Products Affected

- *valsartan*

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

Valsartan-Hydrochlorothiazide

Products Affected

- *valsartan-hydrochlorothiazide*

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

Vancomycin HCl

Products Affected

- *vancomycin hcl oral capsule 125 mg*

QL Criteria	56 CAPS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vancomycin HCl

Products Affected

- *vancomycin hcl oral capsule 250 mg*

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

Vandetanib

Products Affected

- *vandetanib oral tablet 300 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vandetanib

Products Affected

- *vandetanib oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vectibix

Products Affected

- VECTIBIX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Velcade

Products Affected

- VELCADE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Velivet

Products Affected

- VELIVET

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

Veltin

Products Affected

- VELTIN

ST Criteria	Documented step through TRETINOIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

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

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 75 mg, 37.5 mg*

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

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

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

Veramyst

Products Affected

- VERAMYST

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 100 mg, 300 mg*

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

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

QL Criteria	2 CP24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

VESIcare

Products Affected

- VESICARE

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viagra

Products Affected

- VIAGRA

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

Victory AGM-4000 Test

Products Affected

- VICTORY AGM-4000 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Victoza

Products Affected

- VICTOZA

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	0.3 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Victrelis

Products Affected

- VICTRELIS

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

Viibryd

Products Affected

- VIIBRYD

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 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	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 kit Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 28, 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	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected

- VIMPAT ORAL TABLET

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

Viokace

Products Affected

- VIOKACE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viorele

Products Affected

- *viorele*

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

Viramune XR

Products Affected

- VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR* 100 MG

QL Criteria	3 TB24 Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viread

Products Affected

- VIREAD ORAL TABLET

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

Vivelle-Dot

Products Affected

- VIVELLE-DOT

QL Criteria	0.29 PTTW Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vivelle-Dot

Products Affected

- VIVELLE-DOT

QL Criteria	0.29 patches Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vocal Point Blood Glucose Test

Products Affected

- VOCAL POINT BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Voltaren

Products Affected

- VOLTAREN TRANSDERMAL

QL Criteria	16.7 gm Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Voriconazole

Products Affected

- *voriconazole oral tablet*

PA Criteria	Criteria Details
Covered Uses	Fungal infections
Exclusion Criteria	
Required Medical Information	Diagnosis of invasive aspergillosis or with a serious systemic fungal infection caused by Scedosporium apiospermum and Fusarium spp., for the treatment of esophageal candidiasis that is resistant to treatment with fluconazole and itraconazole, or for the treatment of candidemia in non-neutropenic patients and the following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds that are unresponsive to treatment with fluconazole (Continue therapy for 14 days after the patient is afebrile and blood cultures are negative).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Invasive aspergillosis: 12 weeks, Oral Candidiasis: 3 weeks MAX, Candidemia: 12 weeks
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Votrient

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tabs Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vpriv

Products Affected

- VPRIV

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vytorin

Products Affected

- VYTORIN

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyvanse

Products Affected

- VYVANSE

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 capsule Per 1 Day
Notes/ References	

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

Vyvanse

Products Affected

- VYVANSE

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 CAPS Per 1 DAY
Notes/ References	

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

WaveSense Presto

Products Affected

- WAVESENSE PRESTO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	10 STRP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Welchol

Products Affected

- WELCHOL ORAL PACKET

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

Wera

Products Affected

- WERA

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

Wide-Seal Diaphragm 60

Products Affected

- WIDE-SEAL DIAPHRAGM 60

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

Wide-Seal Diaphragm 65

Products Affected

- WIDE-SEAL DIAPHRAGM 65

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

Wide-Seal Diaphragm 70

Products Affected

- WIDE-SEAL DIAPHRAGM 70

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

Wide-Seal Diaphragm 75

Products Affected

- WIDE-SEAL DIAPHRAGM 75

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

Wide-Seal Diaphragm 80

Products Affected

- WIDE-SEAL DIAPHRAGM 80

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

Wide-Seal Diaphragm 85

Products Affected

- WIDE-SEAL DIAPHRAGM 85

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

Wide-Seal Diaphragm 90

Products Affected

- WIDE-SEAL DIAPHRAGM 90

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

Wide-Seal Diaphragm 95

Products Affected

- WIDE-SEAL DIAPHRAGM 95

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

Wilate

Products Affected

- WILATE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wymzya Fe

Products Affected

- WYMZYA FE

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

Xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto

Products Affected

- XARELTO ORAL TABLET 10 MG, 20 MG

ST Criteria	Documented step through WARFARIN
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto

Products Affected

- XARELTO ORAL TABLET 15 MG

ST Criteria	Documented step through WARFARIN
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xarelto Starter Pack

Products Affected

- XARELTO STARTER PACK

ST Criteria	Documented step through WARFARIN
QL Criteria	2 packs Per 325 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeljanz

Products Affected

- XELJANZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xenazine

Products Affected

- XENAZINE ORAL TABLET 12.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xenazine

Products Affected

- XENAZINE ORAL TABLET 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xenical

Products Affected

- XENICAL

PA Criteria	Criteria Details
Covered Uses	Body Mass Index (BMI) greater than 30 kg/ m2 OR BMI greater than 27 kg/ m2 with one or more of the required medical info
Exclusion Criteria	Concomitant use of two or more antiobesity agents OR pregnancy
Required Medical Information	Hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg on more than one occasion) OR Dyslipidemia (LDL cholesterol greater than/= 160 mg/ dL: HDL cholesterol less than 35 mg/ dL: Triglycerides greater than /= 400 mg/ dL) OR Type 2 diabetes mellitus OR Coronary heart disease OR Obstructive sleep apnea
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

Xeomin

Products Affected

- XEOMIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xiaflex

Products Affected

- XIAFLEX

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

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 200 MG

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

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	Hepatic Enchephalopathy and Irritable Bowel Syndrome w/ Diarrhea (IBS-D)
Exclusion Criteria	
Required Medical Information	FOR HEPATIC ENCEPHALOPATHY: Member is 18 years and older and had a therapeutic failure or contraindication to Lactulose. FOR IRRITABLE BOWEL SYNDROME WITH DIARRHEA: Member has been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, a 10-week treatment free period from the previous course of therapy must be documented.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year - hepatic encephalopathy, 14 days for Irritable Bowel Syndrome w/ Diarrhea (IBS-D)
Other Criteria	
QL Criteria	3 tablets Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xopenex HFA

Products Affected

- XOPENEX HFA

ST Criteria	Documented step through VENTOLIN HFA
QL Criteria	2 inhalers Per 180 DAYs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xtandi

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xulane

Products Affected

- XULANE

QL Criteria	0.11 patches Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyntha

Products Affected

- XYNTHA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyntha Solofuse

Products Affected

- XYNTHA SOLOFUSE INTRAVENOUS*
  KIT 3000 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/cataplexy-xyrem.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 29, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Yasmin 28

Products Affected

- YASMIN 28

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

YAZ

Products Affected

- YAZ

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

Yervoy

Products Affected

- YERVOY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zaleplon

Products Affected

- *zaleplon*

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

Zavesca

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid OTC

Products Affected

- ZEGERID OTC

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

Zelapar

Products Affected

- ZELAPAR

ST Criteria	Documented step through SELEGILINE
QL Criteria	2 TBDP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zemaira

Products Affected

- ZEMAIRA

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

Zenchent

Products Affected

- ZENCHENT

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

Zenchent FE

Products Affected

- ZENCHENT FE

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

Zeosa

Products Affected

- ZEOSA

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

Zetia

Products Affected

- ZETIA

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zetonna

Products Affected

- ZETONNA

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziana

Products Affected

- ZIANA

ST Criteria	Documented step through TRETINOIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zioptan

Products Affected

- ZIOPTAN

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziprasidone HCl

Products Affected

- *ziprasidone hcl*

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

Zirgan

Products Affected

- ZIRGAN

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

Zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 CAPS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 2.5 mg*

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	0.2 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet 5 mg*
- *zolmitriptan oral tablet dispersible 5 mg*

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	3 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral tablet dispersible 2.5 mg*

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	0.2 TBDP Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate*

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

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

ST Criteria	Documented step through ZOLPIDEM OR ZALEPLON
QL Criteria	1 tabs Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zometa

Products Affected

- ZOMETA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- ZOMIG NASAL SOLUTION 5 MG

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	0.2 SOLN Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovia 1/35E (28)

Products Affected

- ZOVIA 1/35E (28)

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

Zovia 1/50E (28)

Products Affected

- ZOVIA 1/50E (28)

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

Zovirax

Products Affected

- ZOVIRAX EXTERNAL CREAM

ST Criteria	Documented step through ORAL ACYCLOVIR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zymaxid

Products Affected

- ZYMAXID

QL Criteria	2.5 SOLN Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zytiga

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 TABS Per 1 DAY
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyvox

Products Affected

- ZYVOX ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Infection
Exclusion Criteria	Zyvox is NOT covered for members with isolated causative organisms not susceptible to Zyvox or for the treatment of gram-negative infections.
Required Medical Information	Documented vancomycin resistant enterococcus (VRE) infection or documented methicillin resistant staph aureus (MRSA) infection
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Approval: 1 month
Other Criteria	Initial therapy of 10 doses will be covered to assure that therapy is not delayed while the prior authorization request is being reviewed.Extended Approval: Maximum of 3 months depending on the infective organism and infection site
QL Criteria	28 TABS Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zyvox

Products Affected

- ZYVOX ORAL SUSPENSION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Infection
Exclusion Criteria	Zyvox is NOT covered for members with isolated causative organisms not susceptible to Zyvox or for the treatment of gram-negative infections.
Required Medical Information	Documented vancomycin resistant enterococcus (VRE) infection or documented methicillin resistant staph aureus (MRSA) infection
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Approval: 1 month
Other Criteria	Initial therapy of 10 doses will be covered to assure that therapy is not delayed while the prior authorization request is being reviewed.Extended Approval: Maximum of 3 months depending on the infective organism and infection site
QL Criteria	150 SUSR Per 1 FILL
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

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